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**Leading Health Information Management in Jamaica: An Evaluation of  
Policy and Practice**

**Nola P. Hill-Berry**

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for  
the degree of Doctor of Education

University of Huddersfield

July, 2018

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## **Abstract**

Participants from the four health regions were invited to participate in a study which focused on Leading Health Information Management in Jamaica. The purpose of this convergent-parallel mixed-methods study was to understand their views concerning how leadership was practiced in HIM, and the policies and procedures that guided the HIM practice. The interview results corroborated those of the survey and revealed a hybrid of leadership practices in HIM in Jamaica. The results highlighted a number of issues regarding leadership in the HIM practice; recruitment, retention, succession planning among HIM practitioners; and the policies and procedures guiding the practice. The results suggested that HIM practitioners, policy makers and academic leaders will need to work synergistically to address the issues raised and to revise the policies and procedures to reflect current practice. The results also suggested a need for more in-depth studies into HIM practices through the lens of leadership; and the introduction of leadership and professional development programmes to build the capacity of HIM leaders and to enhance the HIM practice.

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## **Dedication**

Dedicated to my colleagues and all other stakeholders in the Health Information Management profession, in particular HIM academic leaders, practice leaders and policy leaders. Special dedication to my husband Chuck, for his support during my doctoral journey.

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To God be the glory.

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- All my colleagues who started with journey with me and encouraged me along the way.
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## **Academic Biography**

**Nola P. Hill-Berry** is a research student at the University of Huddersfield. Nola is also a lecturer at the University of Technology, Jamaica with responsibility for leading the health information management courses of study. She is currently the Membership Secretary and Director of Member Services for the Institute for Educational Administration and Leadership - Jamaica (IEAL-J), and is a member of the Commonwealth Council for Educational Administration and Management (CCEAM). She is also a member of the British Educational Leadership, Management and Administration Society (BELMAS). Nola has special interests in leadership for organisational effectiveness, professional development, and leadership in HIM. Her extended interests include programme design and health informatics. Nola may be contacted at [chuckberry.nhb@gmail.com](mailto:chuckberry.nhb@gmail.com).

## **Chapter 1 – Introduction**

### **1.1 Motivation for this study**

The researcher is a lecturer in HIM for nine years and she has also worked in the HIM practice for over ten years. These experiences, in both contexts, have allowed the researcher a number of opportunities for interactions with HIM practitioners. During this time, a number of issues have surfaced regarding leadership and succession planning in HIM such as the reluctance of practitioners to take on leadership roles due to lack of confidence, not having people or policy leadership, lack of leadership capacity in the HIM staff, and challenges identifying people to fill HIM leadership roles, among others. In different settings, the researcher has had several discussions with colleagues regarding these issues and has deemed these important issues to be addressed. Hence the researcher thought it prudent to carry out this investigation to better understand what was happening in the HIM practice in order to have the relevant research evidence (empirical data) to inform decisions regarding teaching, leading and managing HIM, and how these issues can be addressed.

A renowned professor argues that leadership is an emergent and highly contested field that involves moulding character and building capacities. He argues that although situations make it challenging to identify leadership, there is no doubt that leadership should offer prospects for personal and professional development of individuals; and for continued growth of organisations (Miller, 2013b). This study takes note of Miller's view and explores leadership, policy and practice in the context of health information management (HIM) in Jamaica.

Health information management started as a profession in North America in 1929 when the need was identified for standardisation in medical record documentation and this was communicated to wider cross-sections through annual hospital conferences (Huffman, 1994). As

interest in the subject grew, medical record workers in Canada and the United States were invited to a special medical record conference in Boston. This was deemed a very successful conference as from this meeting, the Association of Record Librarians of North America (now American Health Information Management Association) was formed with its main object to enhance the quality of medical records (Huffman, 1994). This initiative sparked wider and still growing interest in the subject and in 1971, the Jamaica Medical Records Association (JMRA) was formed.

Initially, training for this profession was an apprenticeship programme in hospitals but it was soon discovered that although based on a specified curriculum, the hospital program was inadequate to meet the growing needs and the program was subsequently moved to schools that were granted approval for formal training. This was the springboard for the now internationally recognised HIM education and myriad related careers geared towards training of HIM practitioners (Huffman, 1994; Johns, 2002). In recent years, the concept of leadership is regularly discussed in HIM departments and associations; therefore, it is important to explore how leadership is practiced and developed in HIM.

This study notes existing leadership practices; examines the policies that are used to guide HIM practice in Jamaica's public health institutions; and explores strategies that may be adopted to position practitioners to become leaders in the field of HIM in Jamaica. This study provides insight into established policies and leadership practices among select groups of HIM practitioners and other stakeholders in Jamaica.



## **1.2 Background of the study**

Several studies, qualitative and quantitative, have been undertaken to explore leadership in various contexts but in recent years there seems to be a special attention on educational administration and leadership. To this extent, in educational organisations, a number of strategies have been adopted to address leadership issues in Jamaica, such as the Ministry of Education (MOE) making provisions for all principals to access leadership training through the National College for Educational Leadership (NCEL); new courses of study being offered at tertiary institutions; and the Institute for Educational Administration & Leadership - Jamaica (IEAL-J) emphasising the need for evidence-led leadership across the education sector - from nursery to University. But, what about leadership in other organisations and disciplines such as health information management?

On the international scene, a number of HIM practitioners are now pursuing graduate studies in leadership and also professional certification in leadership in health information technology (University of Minnesota, 2014). This is an indication that there is interest in HIM leadership, an interest which also underpins this research. This study examines some of the policies and ways in which leadership is practiced and developed in various health organisations and settings; and how these practices can be benchmarked to ensure best practices in HIM in Jamaica for staff enhancement, personal development, succession planning, and building leadership competencies. Further, this study explores how all these ingredients – HIM leadership, policy, practice, and succession planning - can be amalgamated for organisational effectiveness (Hill-Berry, 2015).

In the Jamaican context, there are a number of issues affecting leadership in HIM such as:

- the reluctance of staff to take on leadership roles because of lack of confidence;
- not having people and policy leadership; and

- the difficulty experienced by academic leaders in Jamaica, to identify people to assume leadership roles, and to outsource leadership capacity.

Additionally, there are several issues with leadership and succession planning such as:

- lack of confidence among HIM personnel;
- lack of capacity in the existing staff; - resulting in
- the challenges faced by the Ministry of Health to identify people to fill leadership positions.

Different types of organisational culture will determine the leadership practices adopted as well as the effectiveness of organisations; but how effective is leadership in those organisations? HIM practitioners may have excellent leadership competencies. However, for various reasons, some HIM practitioners may never take the initiative to lead or participate in leadership roles. Could it be that there needs to be different practices of leadership to “un-shelter” those individuals? While this is yet to be explored, there are a number of people with leadership capabilities who have not led, and may never lead because they fear taking on leadership roles or they do not want to take on the responsibility for leading or managing. Also, some people yearn for even one opportunity to get involved, but are never granted such privilege. In such instances, an appropriate question to ponder is: what can be done to harness those skills and build capacities to strengthen current practice, to more effectively lead HIM in Jamaica?

Leadership and expertise in HIM are limited in Jamaica; hence the searches offshore by the Ministry of Health (MOH) and the University of Technology, Jamaica for external expert advice. The University of Technology, Jamaica (UTech, Jamaica) which is the sole training institution for HIM practitioners in Jamaica, has also sought expertise from Canadian partners. UTech, Jamaica is benchmarking different aspects of leadership in HIM from Canada. Consequently, to

assist with formal HIM training, the academic institution has identified an external examiner from a Canadian university for its Health Information Technology / Health Information Management courses of study. In the meantime, both HIM practice leaders and academic leaders in Jamaica are continuously benchmarking with international organisations to fill such gaps where HIM expertise is needed. Based on the aforementioned, it therefore seems prudent to explore the context of leadership as models for the development of leadership in HIM in Jamaica.

In addition, in an effort to strengthen its e-health initiative, the Ministry of Health, Jamaica has entered a memorandum of understanding (MOU) with the Canadian Health Information Management Association (CHIMA). The purpose of that MOU is to augment the transformation of HIM services in Jamaica, particularly in relation to meeting some of the new health data needs and transitioning to electronic health records (EHR); and in terms of providing expertise that will contribute to the governance, security, privacy and confidentiality of health information in the EHR context.

### **1.3 Positionality**

Cognisant that a researcher's positionality can influence the process and outcome of a research, it is important to declare one's position as insider/outsider and how it may have impacted the research. Having worked in the HIM practice for approximately 10 years and then having taught (and still teaching) HIM for nine years, the researcher has had a number of opportunities to interact with participants in the study. The researcher was therefore an insider (HIM academic leader); and an outsider (researcher). The researcher's positionality informed the selection of the research topic - leadership in HIM. As Mills and Stewart (2015) advanced,

the researcher was aware that her positionality would allow for easy access to research participants, acceptability and adaptability in the field, and with prior knowledge of what goes on in the field, a better understanding of the position of participants. As regards participants, the researcher considered the acquaintance with participants as their colleague in the practice, and or their lecturer in the HIM training institution, or colleague in the academic leadership group; and how participants could have responded to her as a researcher based on those previous or existing relationships. With the awareness that the way participants relate at work was more sheltered than how they communicated in ‘out-of-work’ settings, the researcher also considered the context in which the research was conducted and what that could have meant for the responses elicited (data collected).

Concerning the researcher’s own positionality, there is no doubt that her position as ‘insider’ has impacted the research process; and her acceptance, understanding and interpretation of any data gleaned during her interaction with participants. While the researcher believes that her ‘insider’ position worked to her advantage in terms of gaining access to participants and appropriately rapping with them, the researcher was always conscious that her positionality could create some bias in the research process (Kipnis & Broeckerhoff, 2016). In this instance, the researcher experienced a positive bias in terms of the high response rate. The researcher also believes her positionality changed as she interacted with participants on the field (Kidney & Manning, 2017). Also, knowing what usually happens in HIM, the researcher believes that interviewees may have ‘polished’ some of their responses to the interview questions to tell the researcher what they thought she wanted to hear, instead of reporting what was happening in the field.

#### **1.4 Statement of the Problem**

Ideally, the policies and practices governing HIM must be periodically assessed to enhance recruitment, retention and succession planning among HIM practitioners in Jamaica. These reviews require the expertise of HIM leadership and other stakeholders; but leadership is lacking. Leadership skills are found in every individual but the challenges still remain identifying the potentials and harnessing those skills.

Two of the main drawbacks of leadership are the fear that it only resides in a few; and the reality that those in leadership positions abuse the related power. Unfortunately, the current system allows for the continuation of such challenges. However, nurturing such challenges will only hinder growth – both individual and organisational – and may negatively affect relationship building, capacity development and succession planning which are vital activities particularly impacting leadership in organisations. Reviewing the policies and adopting more inclusive leadership practices could allow for organisations to build competencies and make better use of their human resources. Hence, the researcher examined leadership policies and practices among HIM practitioners in public health settings in Jamaica.

#### **1.5 Purpose of the Study**

This study serves three main purposes: to extend the body of knowledge in organisational leadership; to identify leadership models/practices that can be adopted for more effective practice in the Jamaican setting; and to pinpoint solutions to leadership problems especially those existing in organisations servicing HIM.

## **1.6 Research Objectives**

Consistent with the purpose of this study, the objectives were to:

1. Determine current leadership practices in Jamaican organisations involved in the leadership and management of HIM practitioners.
2. Determine the role and impact that HIM leaders have in succession planning (capacity building and professional development) and the development of the HIM profession; and how such impact was captured and measured by internal and external stakeholders.
3. Ascertain possible interventions by academic and policy leaders that could help to address the challenges identified regarding recruitment, retention and succession planning among HIM practitioners in Jamaica.
4. Ascertain possible roles that may be played by other stakeholders in the recruitment, retention and succession planning of HIM practitioners in Jamaica.
5. Identify appropriate solutions to the problems of leadership in HIM in Jamaica.

## **1.7 Research Questions**

This study sought to answer the following questions:

1. What leadership practices currently exist in Jamaican organisations involved in the leadership and management of HIM?
2. (a) What role and impact do HIM managers have in succession planning (capacity building and professional development) and the development of the HIM profession?  
(b) How has this impact been captured and measured by \*internal and external stakeholders?

3. What can \*\*academic and policy leaders do to address the challenges identified regarding recruitment, retention and succession planning among HIM practitioners in Jamaica?
4. What role, if any, do external stakeholders play in the recruitment, retention and succession planning of HIM practitioners in Jamaica?
5. What policies and procedures are in place to guide HIM orientation, training and practice in Jamaica?

\*Internal stakeholders are individuals and groups within the Ministry of Health with special interests in HIM such as HIM practitioners, health planning and policy directors, regional health officers, and human resources managers.

\*External stakeholders are individuals, groups outside of the Ministry of Health with special interests in HIM such as academic leaders and representatives from other health disciplines, and health-related agencies.

\*\*Academic leaders, as used in this study, are individuals charged with leading and managing the HIM courses of study at the sole HIM training institution in Jamaica – head of school, programme leaders, and members of the HIM academic advisory committee. Policy leaders are the HIM director and other policy directors in the Ministry of Health.

## **1.8 Significance of the study**

It is expected that this study will have an impact in different ways, primarily through (A) a contribution to the body of knowledge related to organisational leadership, particularly leadership in HIM, (B) the development and implementation of HIM policies at institutional and national levels; and (C) the practice of HIM leaders/ academic leaders. For example:

A. Contribution to the body of knowledge

- a. In Jamaica and globally, the HIM literature emanates from varied research approaches – quantitative, qualitative, and multiple methods. This study takes a mixed methods approach and might be expected to add new insights into an appropriate pairing of data collection methods that can be used as an excellent combination to validate data, and to provide “richness” to the data (Creswell, 2008).
  - b. This study also intends to contribute to the literature in HIM by evaluating its practices through the lens of leadership.
- B. Contribution to National and Institutional policies
- a. National policies for standardisation of HIM processes regarding recruitment, retention and succession planning, equity of opportunities for upward mobility, and clarity regarding granting of benefits such as HIM training and study leave.
  - b. Institutional level policies regarding how the HIM departments should recruit, retain, and develop HIM practitioners; how to equip HIM practitioners to assume positions of leadership and responsibility; and the implementation of strategies/ initiatives geared toward achieving institutional goals.
- C. Contribution to the practice of HIM in Jamaica in relation to:
- a. the recruitment, retention, and succession planning behaviours of HIM personnel
  - b. compliance with established procedures and guidelines and adherence to the profession’s code of ethics in recruiting, retaining and developing HIM practitioners
  - c. leadership and the types of leadership practices adopted in Jamaican organisations servicing and managing HIM.



## **1.9 Delimitations of the Study**

For any research, it is important to state the scope of the study so that readers will know what to expect. The study did not cover HIM practitioners in private health institutions. Rather, this study focused only on HIM practitioners in public health institutions in Jamaica, policy leaders, and academic leaders in the field of HIM.

For the purpose of this study, HIM practitioners are classified as those who are currently working in public health facilities and are practicing HIM; and stakeholders are other groups associated with the Ministry of Health with special interests in HIM such as academic leaders and representatives from other health disciplines, regional health offices, and health-related agencies. Participation in this study was therefore delimited to those who were practicing and leading HIM as part of their job role; and those whose job role require them to have frequent relations with HIM practitioners.

## **1.10 Limitations**

One limitation was the absence of some voices from the research. There was a restriction on the participation from HIM practitioners in the smaller health facilities located in the more rural areas of Jamaica. This is because it would have been too costly and onerous on the researcher to travel to all these facilities for one or two survey participants. Another limitation was the paucity of prior research specific to the (Jamaican) context in which the study was conducted. Hence, not much was found in terms of literature to underpin the topic that was being investigated.

### 1.11 Definition of Terms

This section highlights some definitions which are pertinent to this study. In order to appreciate this research, an appropriate understanding of the terms used is critical. It is therefore important that the readers of this document understand the following:

*Academic leaders* – individuals charged with leading and managing the HIM courses of study at the sole HIM training institution in Jamaica.

*Canadian Health Information Management Association (CHIMA)* – the national association responsible for representing HIM professionals and the accrediting body for HIM programmes in Canada.

*Health information management (HIM)* - the profession trained for and committed to delivering high quality patient care through the effective handling of patients' health information and other healthcare data (Johns, 2007).

*Jamaica Medical Record Association (JMRA)* - the professional body aligned to and representing HIM practitioners in Jamaica.

*Policy leaders* - the HIM director and other policy directors in the Ministry of Health.

*Stakeholders (internal)* – individuals, groups within the Ministry of Health with special interests in HIM such as HIM practitioners, health and policy directors, and human resources managers.

*Stakeholders (external or other)* - individuals, groups outside of the Ministry of Health with special interests in HIM such as academic leaders and representatives from other health disciplines and health-related agencies.

## **1.12 Structure of the Remainder of the Thesis**

Chapter one introduces the study and looks at the background, problem statement, purpose, research objectives, research questions and significance of the study through to the delimitations and definition of terms used in the study. The remainder of the thesis is comprised of seven chapters.

Chapter two is the theoretical framework. Here, the researcher gives a description of the theories that inform this study. These are Chaos Theory, Human Capital Theory, Professional Identity Theory, Distributed Leadership, as well as Transactional and Transformational Leadership.

Chapter three contains the literature review. Here the researcher examines the work that others have done in relation to the subject and what other leadership gurus have said about the topic of focus. The literature review is organised according to headings and includes: Introduction, Overview of Jamaica, Historical and Contemporary context of HIM in Jamaica, Views surrounding leadership and leadership experiences, Current leadership practices, Health Information Management, and Leadership in HIM; Recruitment, retention and succession planning among HIM practitioners in Jamaica; HIM Training and Practice, and HIM policies and procedures.

Chapter four, the research methods and design, discusses the methods used for collecting and analysing data for this study. This chapter is organised according to these headings: philosophical stance, overview, research design, population, sample size, methods for data collection, report on a pilot study, reliability, validity, data analysis, ethical issues, and the timeline for completion of the research.

Chapters five and six contain analyses of the findings as garnered through quantitative and qualitative data collection methods. These chapters capture participants' responses in relation to HIM leadership and other stakeholders' roles in recruitment, retention, and succession planning and the development of the HIM profession in Jamaica, as well as the results in relation to policies and procedures used to guide the HIM practice in Jamaica.

Chapter seven is the discussion and evaluation chapter. It discusses the significance of these findings in relation to the information found in the literature to make sense of the data.

Chapter eight contains the implications and conclusions drawn from the study which could be valuable in helping to inform policies and practices relation to leading HIM in Jamaica; as well as to inform other studies.

## **Chapter 2 - Theoretical Framework**

According to Miner (2005), “Theory is the cornerstone of any science. It provides the ideas that fuel research and practice” (p. 5). A theory is a sweeping statement or a series of such statements that may be used to logically explain an observable fact or occurrence. Theories play an important part in research. They serve as springboard and direction for investigating research problems and as guides for classifying and arranging the various components of the research. Theories help the researcher to identify shortcomings, to properly contextualise information, and to discover important subjects that need to be explored. Additionally, theories help to inform further studies and pinpoint specific areas that need intervention (Wiersma & Jurs, 2009). It is therefore reasonable to agree that theories help to “determine the number and kinds of phenomena that are relevant to a study [since] a theory tells a social scientist what to observe and what to ignore” (Lunenburg & Ornstein, 2012, p. 3).

The researcher’s reading of the various theories led to a focus on specific aspects in order to connect these theories to better understand what was happening in HIM and how to better put those into perspectives. For example, the leadership theories were chosen because a number of the issues were related to leadership and the researcher needed to relate these to the practice of HIM. Also, the chaos theory was selected because of what is happening in the practice where people do not work according to a plan and it appears difficult for people to explain what is happening in the practice. Burns (2002) said leadership that is done along with the chaos theory is easier to practice than it is to understand. The current HIM practice seems to lend itself to how the chaos theory is described in that work is being done, there are elements of leadership in all categories of staff, and each individual is considered an important agent in the organisation’s processes, but it is difficult to explain leadership.

This study is informed by several theories: Chaos theory, Human Capital theory, and Professional identity theory. Leadership models - particularly transactional leadership and transformational leadership, as well as distributed leadership - are discussed around these theories.

## **2.1 Chaos Theory**

Chaos theory advocates that any system can experience growth and development when it recognises the need to change and develop. In any system, a relatively small change can result in chaos and the need for even more profound changes (Middleton, 2012). According to Burns (2002), it is unfortunate that the theory is named “Chaos” because chaos implies randomness and that is not the theory’s intent. While chaos theory implies a system that can be difficult to analyse, it describes a system where the output does not differ from the input. In such system, the effects may be disruptive but there may be some sensitivity to the initial conditions and outcomes may be unpredictable but out of such systems, there can be major transformations.

Chaos theory implies the absence of rules and lack of systematic processes. This is only a part of the problem in HIM in Jamaica. According to Burns (2002), “Chaos theory teaches that long-term success is not ensured by the plan, but by sticking to the purpose and core values of the organization” (p. 50). In chaos theory, understanding of minor changes can eventually cause unexpected, major changes in an organisation (Koehler, Kress, & Miller, 2014). With this theory, having certain long term plans in place in an organisation can still be extremely inadequate, and this “can lull an organization into a kind of false sense of security” (Burns, 2002, p. 50).

The propagation of chaos theory has led to a number of efforts to incorporate some of its principles in organisational leadership and management (Galbraith, 2004). In chaos theory, leadership is not owned and practiced by a designated leader, people in leadership positions, or management team. Rather, leadership is widely practiced throughout the organisation because in chaotic systems, each individual is considered an agent with possible access to information that can be critical to the organisation's processes (Burns, 2002).

Chaos theory teaches that systems may behave in spontaneous and unpredictable ways but in such situations, organisational leadership and management work together not through a plan, but by adhering to the organisation's purpose and core values. Leadership that is done along with chaos theory is easier to practice than it is to understand (Burns, 2002). A number of ideas can be gleaned from the chaos theory that can be used to address varied issues in leadership and management (Galbraith, 2004) in HIM.

## **2.2 Human Capital Theory**

Human capital theory was propagated by Gary Becker in 1964. This theory is based on the premise that education and training advance the knowledge, skills and educational capacity of workers. The assumption of this theory is that education advances earnings and productivity mainly by providing individuals with knowledge, and a range of skills including problem solving skills (Becker, 1994). This improved education brings about some level of satisfaction which leads to increased productivity and ultimately raises earnings (Piper, 2012).

Similar conventions often are present in various Jamaican settings in which leading, managing and training HIM are discussed. Like Becker (1993), Jamaican HIM stakeholders believe that investments in HIM training will accrue to increased education and skills, and these in turn will

increase productivity. Higher productivity will then lead to higher earnings and in turn more economic benefits. But, there is also a different view. It is also believed that this higher education may be a risk to the HIM profession because the wheels of employment may not turn as planned (van, d, 2010); and as HIM practitioners become more academically advanced, they usually leave for better job opportunities. A balance of both views is heavily dependent on the way HIM is taught, led and managed in Jamaica.

Becker (1962) described human capital as resources embedded in people. Human capital is produced by changes in people that cause them to develop skills and capabilities that enable them able to engage in new tasks (Coleman, 1988). Human capital may be acquired through varied means including education (formal and informal) and experience. This formal education may be accumulated through any level of schooling or vocational training; the informal may be amassed while learning in different settings such as self-studies and learning by doing in on-the-job settings. There are reserves and arguments in terms of how this investment should be made and whether such investment is really in individuals or in organisations. In either instance, the results for any organisation are capacity building and professional development which are vital for succession planning (Tittenbrun, 2017).

In the context of succession planning among HIM practitioners, “education and training are the most important investments in human capital” (Becker, 1993, p. 17). Used in context here, this theory is based on the notion that formal education is essential to expanding the productive capacity of the HIM population; since the provision of formal education is deemed an important investment (Almendarez, 2013). Implied in this context is that formal higher education will make HIM practitioners more productive, and this will be recognised by employers who subsequently compensate employees relative to their higher levels of education (van, d., 2010).



However, this education and training can occur outside of the formal education setting through on-the-job training which, by the way, could be just as large an investment as formal training (Becker, 1994); and, like formal training, can have similar effects on employment, earnings, and other variables of economic interests (Becker, 1962).

In this dynamic health environment, investing in HIM is seen as a positive move toward increased earnings. Human capital theory suggests a positive correlation between educational level and income because it “specifies a particular mechanism through which this correlation results: education increases skills, and these in turn increase productivity, higher productivity is then rewarded through higher earnings” (Strober, 2001, p. 214). However, one concern that has been expressed about this theory is that while human capital theory focuses on the supply side, the demand side of the labour market is not considered; and this should be a key consideration because organisations’ human resources needs and the actions of human resource departments also help to determine employment and earnings. Financial policies and established government pay schemes are also determinants to employment and earnings (Strober, 1990).

HIM succession planning is often linked to human capital development because in the human capital theory, significant attention has been given to education and training. As Becker (1994) asserted, education and training are vital investments in human capital. In fact, these are important components of human capital, that can incur high costs but the benefits, when acquired, will increase capabilities to execute activities of economic value (Marta, Sanzo Perez, & Trespalacios Gutierrez, 1999). Education and training of HIM practitioners are therefore issues of paramount importance and those who lead and manage HIM will need to make decisions about how these education and training are done. In HIM much learning and training occur outside of the formal education system by way of on-the-job training. On-the-job training

takes several forms. In some instances such an investment is as large as educational training, and in other instances, the investment in on-the-job training may be even greater (Becker, 1993).

Like many Jamaicans, some individuals and even poor countries are reluctant to invest in education if the country does not provide the funding. They also believe that a country can realise economic growth only when its human capital and physical capital rise together. In such instances, it appears that human capital is equally important as physical capital in raising the country's economic output (Breton, 2014). But according to Stanfield (2009), "government investment in human capital is one of the least effective ways to raise the poor to decent levels of income and health, and is much more likely to prevent and pervert the growth of human capital than promote it" (p.100).

Another concern is the type of human capital and the impact such capital could have on organisational life; and in the Jamaican setting arguments around human capital are tinted with social capital versus cultural capital. Social capital is engendered "through changes in the relations among persons that facilitate action" and it "exists in the relations among persons" (Coleman, 1988, S100). Social capital concerns connections and social networks (Bourdieu, 1986). The broader and more influential one's social networks become, his or her opportunities become more favourable and tend to blossom into socioeconomic success (Edgerton & Roberts, 2014). Meanwhile, an institutionalised form of cultural capital (Bourdieu, 1986), described by Edgerton and Roberts (2014) as the "officially accredited" form, is about educational qualifications and merits. Cultural capital is generated through processes of garnering technical and educational competencies; and it is about educational and occupational successes which burgeon into economic capital (Edgerton & Roberts, 2014).

According to Coleman (1994), “all social relations facilitate some form of social capital” (p. 105). Social capital is integral to creating human capital. However, at times the social capital dominates the human capital (Coleman, 1994); therefore corruption becomes accepted and people accept that as a part of everyday life and appear to turn a blind eye to it (Miller, 2013a). In Jamaica, this is what obtains and social capital becomes accepted rather than cultural capital, to the point where it is the social capital that awards promotions and positions over the cultural capital. Even if there are established frameworks in Jamaica, the social network is far more dominant in recruitment and progression than any formalised structure (ibid), a situation which presents a tension between human and social capital. Nevertheless, HIM can be taught, led and managed in such a way that the outcome of any investment in human capital in HIM can be mutually beneficial to all stakeholders.

### **2.3 Professional Identity Theory**

Within the Jamaican context, rather than focusing on their personal goals and ambitions, and the worth of their jobs, people generally want to identify with a profession that is presumed to be well-paid and highly recognised. Hence, many people struggle with the issue of professional identity and HIM practitioners are not immune to such scuffles. Coined by Schein and Schein (1978) professional identity describes the established collection of attributes, beliefs, experiences, motives, and values that relate to how people define themselves in their professional roles. Slay and Smith (2011) expanded that professional identity deals with people’s notion about their professional roles based on these attributes, beliefs, experiences, motives, and values that are essential to their careers. They noted that career success is often linked to proper

construction of professional identity and that this relationship (of career success and professional identity construction) is essential to a number of careers.

Professional identity is distinguished by people's education, attitudes about their profession, their attitudes towards the services they deliver to their clientele, and their professional development activities which encapsulate continuing education and other activities they engage in and the related groups with which they associate (Hayden, 1991). Hotho (2008) considers professional identity as one of the many social identities of an individual as it allows them to hold certain values and have a sense of belongingness and stability with which they can socialise into the professional community. However, the *modus operandi* of Jamaican HIM practitioners, particularly in relation to their attitudes toward their profession and succession planning practices, tells that they do not necessarily feel that sense of belongingness and stability; neither do they socialise well into the professional community. The reasons may be based on how the forming of their professional identity was initialised.

HIM practitioners' professional identity is generally formed during initial orientation and socialisation into the profession, during their training, or during their practice; but may be altered and affected by internal influences such as leadership, and external influences such as social gatherings. Their professional identity develops with involvement in social and professional "communities of practice" that prepare them for their careers (Trowers, 2016). Hence, this identity develops over long periods of time and throughout their career and evolves as the profession evolves (Thomas-Gregory, 2014). This professional identity is usually manifested in their professional behaviours, and these behaviours are oftentimes influenced by personal values and opportunities in professional practice, as well as personal perceptions of professionalism formed in academic settings or through engagement with professional organisations (Bolding,

2013). HIM practitioners are not necessarily engaged with many professional organisations, but an understanding of their perceptions of the importance of their work will provide further understanding about their perception of professional identity (Colmer, 2017).

## **2.4 Distributed leadership**

A species of distributed leadership could complement the theories just described. Harris and Spillane (2008) affirmed that leadership is better affected using a collaborative approach and recognising individuals for their efforts. One such collaborative approach, distributed leadership, is a holistic, social process of leadership that works through multiple interactions of individuals and within various relationships (Bolden, 2011). Harris (2008) described distributed leadership as a situation where leadership is shared and practiced among individuals in an organisation. It therefore involves more interaction of individuals than individual decision making. In such situation, a group of individuals who hone specific abilities merge those abilities to provide leadership within their groups or organisations.

Distributed leadership is a way of viewing leadership practices differently in order to uncover potentials within an organisation. Distributed leadership entails a shared practice of leadership within formal and informal groups and networks. The practice recognises that within an organisation there are multiple leaders among whom leadership activities are shared. Instead of actions, distributed leadership focuses on interactions. It is concerned with how leadership is practiced and how that leadership influences changes and improvements within that organisation. With distributed leadership, the idea is that the work of all those who contribute to leadership practice is acknowledged regardless of how they are designated as leaders (Harris & Spillane, 2006).

Hill-Berry (2015) argued that organisations can use distributed leadership as a strategy to build future leaders and to propel organisational effectiveness. Distributed leadership could play a vital role in organisational restructuring as it could cause horizontal structures to be more effective.

“Distributed leadership does not imply that the formal leadership structures within organisations are removed or redundant. Instead, it is assumed that there is a powerful relationship between vertical and lateral leadership processes. It also means that those in formal leadership roles are the gatekeepers to distributed leadership practice” (Harris, 2008, p. 174-175).

As described by Greenfield, Braithwaite, Pawsey, Johnson, and Robinson (2009), the nature of distributed leadership is such that parties are interacting and sharing expertise which lead to learning while building capacity and fostering synergy. Distributed leadership cannot be forced or imposed. Rather, this type of leadership is coordinated through an amalgamation of learning opportunities, shared professional learning and collaborative professional relationships (Colmer, 2017). Spillane (2009) elucidated that in a distributed leadership situation, leaders are dependent on the organisation and the activities being undertaken. Therefore, akin to the chaos theory where leadership is widely practiced throughout the organisation (Burns, 2002); “the distributed perspective allows for the possibility that anyone in the [organisation] may take responsibility for leading and managing” (Spillane, 2009, p.72), although not everyone will be leading and managing.

Using a distributed leadership framework can allow HIM leaders to reflect on and examine their own practice, as well as the leadership practices within their organisations. Distributed leadership can be used to facilitate change in leadership activity and can be imbued into various

organisational processes to increase growth and development. Further, by distributing leadership HIM organisations can continue to build leadership competencies (Hill-Berry, 2015).

Distributed leadership is centred on thinking and actions and it aids in understanding leaders' actions and activities in varying environments - from embryonic to complex. In a distributed leadership practice, the focus is on leaders' thinking and actions - their actual leadership actions and activities, and these activities are constituted in the interaction of leaders, followers, and the situations in which they engage in leadership activities (Spillane, Halverson, & Diamond, 2004).

In a study conducted by Harris (2008), three evidences were clear. First, there is a correlation between distributed leadership and organisational change; second, the relation is positive; and third, distribution may take different forms, yet organisational outcomes will be affected. These evidences underpin the triple lock of benefits that can be derived from incorporating distributed leadership into organisational processes.

## **2.5 Transactional Leadership**

Transactional Leadership, also known as managerial leadership, focuses on getting tasks done and improving performance levels. This is a style of leadership in which the leader encourages cooperation of followers through both rewards and punishments (Odumeru, & Ogbonna, 2013). Transactional leadership is practiced when organisational leaders reward or punish their followers, depending on their performance. Transactional leadership depends on contingent reinforcement, either positive contingent reward or management-by-exception, the negative active or the passive form. In contingent reward leadership, the leader obtains followers' agreement and assigns tasks based on what needs to be accomplished; and marries these tasks with promised rewards that are 'exchanged' upon satisfactory completion. In

management-by-exception, the leader organises active monitoring of processes to pinpoint deviations from standards, and errors that occur when taking corrective action. In the active form, the leader analyses failures to meet standards; while in the passive form the leader acts only after complaints are received (Bass & Riggio, 2006).

Kumar (2013) found that in healthcare organisations, transactional leadership may be advantageous in helping to meet certain operational targets, but in service improvement, this type of leadership did not prove so effective. This may have been because of its focus since according to (Al-Sawai, 2013) transactional leadership emphasises organisation, supervision and organisational performance. Here, the focus is on accomplishing tasks done and improving performance levels. However, as HIM organisations are highly service-oriented, a transformational type of leadership may be more suited to its needs.

## **2.6 Transformational leadership**

Daft (2010) describes transformational leadership as a “special ability to bring about innovation and change by recognising followers’ needs and concerns, helping them to look at old problems in new ways and encouraging them to question the status quo” (p. 424). It is the type of leadership that inspires followers and that converts followers to believe they have the ability to act on the inspiration of leaders and transcend their own expectations (Pieterse, Van Knippenberg, Schippers, & Stam, 2010); and bring about organisational changes.

Transformational leadership involves four components. These components are: Idealized Influence, Inspirational motivation, Intellectual Stimulation, and Individualised consideration (Bass & Riggio, 2006; Guay, 2011). The Idealized Influence component involves leaders behaving in ways where they are admired, respected and trusted, such that they serve as role



models for their followers. The Inspirational motivation component sees the leaders behaving in ways that inspire and motivate those around them, providing meaning and challenge to their followers' work, and displaying enthusiasm and optimism by igniting team spirit. Intellectual Stimulation involves leaders stimulating their followers to be more innovative and creative by posing questions, and encouraging creativity by causing followers to look at old problems in new ways. With Individualised consideration, leaders are giving special attention to their followers' individual needs for achievement and growth, by coaching or mentoring them. Employing any or a blend of these four components of transformational leadership usually leads to positive results (Bass & Riggio, 2006).

Transformational leadership involves the leader identifying energies in followers, seeking to satisfy their followers' needs, and fully engaging them. This creates of a climate of trust and openness where change and development are encouraged (Basham, 2012). Thus, this type of leadership fosters communal stimulation that gradually transforms followers into leaders and leaders into agents for capacity building (Guay, 2011); and tends to work well since it "has the potential to engage all stakeholders in the achievement of educational objectives" (Bush, 2003, p. 78). Because of the inspirational motivation characteristic of transformational, it could cause HIM practitioners to align with their professional identity (Slay & Smith, 2011), hence displaying more enthusiasm toward their work and more purposefully engaging in professional activities (Guay, 2011). With such change of attitude toward professional activities, transformational leadership could cause HIM leaders to create changes by first seeking to understand the organisation's philosophy and then realigning such with their own ideas (Al-Zefeiti, & Mohammad, 2015).

With transformational leadership, leaders and followers have shared values and common interests (Bush, 2003). This causes change in followers since it involves inspiring others' commitment to goals, challenges them to be innovative problem solvers, and develops followers' leadership capacity by coaching, mentoring, challenging and supporting them. In the practice of transformational leadership, leaders bring about organisational changes as they first seek to understand the culture and then realign such culture with their new vision. Thus, "transformational leaders change their organisations' culture by first understanding it and then readjusting it with their new vision" (Al-Zefeiti, & Mohammad, 2015, p. 2).

One could reasonably support the argument that expertise in transformational leadership is a necessary tool for the effective practice (Leggat, 2009) of HIM. This is so because "transformational leadership succeed in gaining commitment of followers to such a degree that ... higher levels of accomplishment become virtually a moral imperative" (Bush, 2003, p. 77). Further, as Arnold and Loughlin (2013) posited, people who work with transformational leaders are more committed to their work, more highly engaged and more satisfied. However, to avoid any suspicion of politicking, transformational leadership must be cautiously practiced as "when transformational leadership is used as a cloak for imposing the leaders' values then the process is a political rather than collegial one" (Bush, 2003, p.78).

Jointly, these theories are relevant to this research as they help to inform the researcher of the key elements to be studied and having garnered the data, how to put those facts into the correct perspective. The status as at the time of the investigation was frail leadership, along with poor recruitment, retention and succession planning in HIM. However, it is expected that, as highlighted in Figure 2.1, the benefits from the application of certain aspects of the theories would be enhanced leadership and management capacities resulting in improvement in

recruitment and retention, enhanced succession planning, and the availability of policies and procedures that are current and relevant to the HIM practice.

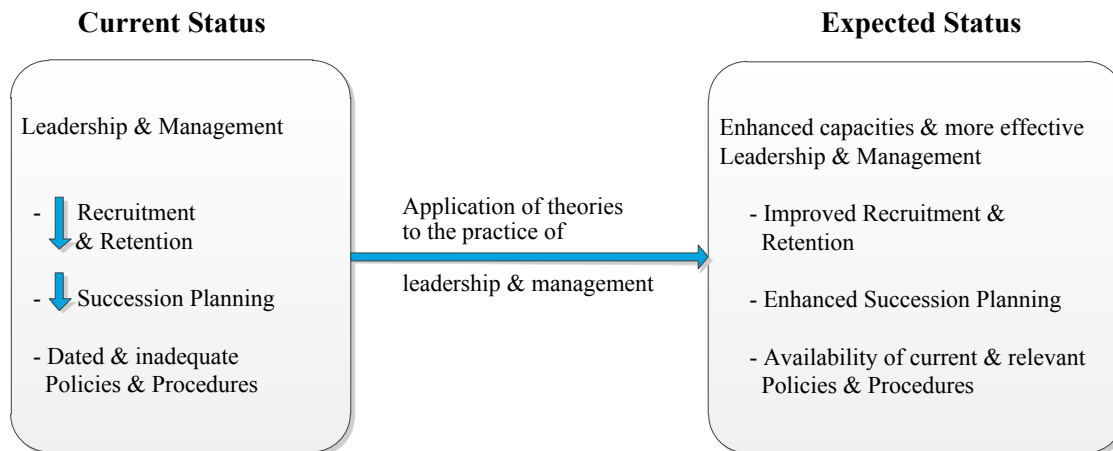


Figure 2.1: Proposed benefits to HIM from application of theories

## 2.7 Summary

This chapter focused on specific theories that could provide foundation for leading and managing HIM in Jamaica. It proposes that, as Figure 2.1 demonstrates, if specific aspects of these theories are applied to leading and managing the HIM profession, overtime there would be enhanced processes and increased levels of effectiveness of both processes.

The next chapter contains a review of the literature.

## **Chapter 3 - Literature Review**

### **3.1 Introduction**

This literature review was a means of accessing and assessing works done by others in the researcher's area of interest in order to understand and investigate the research problem. Among the many reasons for this literature review were to help the researcher to determine what was already known in the area of study, to learn about existing theories in the area of study, to identify inconsistencies or shortcomings in the literature, to know about the views of other researchers that needed further investigation, to identify gaps in the existing literature, and to determine how this study could possibly fill some of the gaps identified (Creswell, 2014; Leedy & Ormrod, 2010). The works consulted included journal articles, books, government documents, reports, newspapers, theses and dissertations, among others.

In order to conduct this literature review, the researcher accessed several databases mainly ProQuest ABI/INFORM Complete, EBSCOHost, ERIC, Emerald, Cengage Learning, and Google Scholar. A number of key words and phrases were used such as leadership and Jamaica; recruitment, retention and Jamaica; leadership and succession planning; health information management and leadership; health information management, leadership and training; health information management and recruitment; health information management and succession planning; and leadership, management and policy development. Alterations of these phrases were also used in order to find some related resources. The searches returned a number of articles which were checked for context, relatedness, study design and outcome. In addition, the researcher consulted a number of related printed books and journals, and specific HIM-related materials such as the policy and procedures manual. These reviews provided a pool of resources from which the researcher was able to draw to strengthen this chapter.

### **3.2 Overview of Jamaica**

Jamaica is located in the Caribbean Sea and is the third largest island in the Greater Antilles. It is about 700 miles south of Miami, Florida, 100 miles south-west of Haiti, and 90 miles south of Cuba. The island has an area of 4411 square miles, and it is 146 miles long from east to west. Jamaica is divided into three counties – Cornwall, Middlesex and Surrey – and these are further divided into 14 parishes. Situated in the county of Surrey and located on the southeast coast of the island, Kingston is Jamaica's capital and largest commercial centre. A British colony since 1965, its official language is English. Jamaica's population at the end of 2017 was over 2.7 million, with an average life-expectancy of 76 years (Europa World Plus, 2018).

Jamaica's health care delivery system is manned by the Ministry of Health that has overall responsibility for policy development and monitoring. The island's health ministry is decentralised into four health regions, namely South East Regional Health Authority (SERHA), North East Regional Health Authority (NERHA), Southern Regional Health Authority (SRHA), and Western Regional Health Authority (WRHA). The country's public health sector comprises 24 hospitals and 356 health centres which together provide health services for the populace (Ministry of Health, 2016). Within each health facility, there is a HIM department that has responsibility for the transactions related to patients' medical records and other health information. These departments are manned by HIM practitioners.

### **3.3 Health Information Management in Jamaica**

**3.3.1 Historical Context.** Health information management, formerly medical record management, is a branch of allied health that deals with understanding the flow of medical information within the health care delivery system; and executing processes to use health

information to ensure continuity of patient care; to protect the interests of the patients, health providers and health institutions; and to support other activities for the enhancement of the health care delivery system. The nomenclature of HIM practitioners may differ slightly in organisations. This because although most organisations are gravitating to health information managers; some still use the titles medical records technicians and administrators, health record technicians and administrators or medical information managers (Huffman, 1994).

Training for HIM practitioners began as an apprenticeship programme but gradually changed with the introduction of a formal curriculum and the initiation of formal training for HIM practitioners in Jamaica over four decades ago (Lewis, 2012). Prior to this, there was an apprenticeship programme in the hospitals where training was provided through short courses conducted on an informal basis; and senior personnel were formally trained overseas. In the early 1970s, meetings were held with the Ministry of Health, the then College of Arts Science and Technology (now University of Technology, Jamaica), and other consultants regarding the need for formal training in all areas, and the need to develop an effective information system and have the requisite skills and competencies in place to man that system. This meeting and subsequent others led to the introduction of the Health Records and Statistics course of study which has grown over the years and has now burgeoned into the Health Information Technology and Health Information Management courses of study (Lewis, 2012).

**3.3.2 Contemporary Context.** Today, training for HIM practitioners is done formally as well as on the job. Less than 20% of the staff is formally trained; which means over 80% have received only on-the-job training<sup>1</sup>. But, to be appropriately equipped to execute their functions,

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<sup>1</sup>An informal head count of HIM practitioners done by the researcher and a senior HIM practitioner in 2016 revealed over 715 HIM practitioners working in the public health facilities in Jamaica; with 83% receiving only on-the-job training.

HIM practitioners need formal training. This formal training is offered by the University of Technology, Jamaica through its Health Information Technology and Health Information Management courses of study (UTech, Jamaica, 2013).

To date, even with formal training and direct employment of graduates of the formal course of study, a number of HIM practitioners are still being employed without the requisite training and on-the-job training continues. However, representation has been put forward to the Ministry of Health by the professional body, the Jamaica Medical Record Association (JMRA), to make the Associate of Science Degree in Health Information Technology the entry level into the profession. With that arrangement, HIM practitioners will come to the job already equipped with the requisite knowledge, skills and competencies (UTech, Jamaica, 2013).

This study explored the leadership policies and practices of HIM practitioners in Jamaica. The guiding research questions were: (1) What leadership practices currently exist in Jamaican organisations involved in the leadership and management of HIM? (2) (a) What role and impact do HIM managers have in succession planning and the development of the HIM profession? (b) How has this impact been captured and measured by internal and external stakeholders? (3) What can academic and policy leaders do to address the challenges identified regarding recruitment, retention and succession planning among HIM practitioners in Jamaica? (4) What role, if any, do external stakeholders play in the recruitment, retention and succession planning of HIM practitioners in Jamaica? and (5) What policies and procedures are in place to guide HIM orientation, training and practice in Jamaica?

The literature review is organised into: a) views surrounding leadership and leadership experiences, b) current leadership practices, c) health information management, d) leadership in

HIM, e) recruitment, retention and succession planning among HIM practitioners; f) HIM training and practice, and g) HIM policies and procedures.

### **3.4 Views surrounding leadership and leadership experiences**

Commenting on leadership, one HIM expert, (Johns, 2002) noted that the process involves leaders inspiring and motivating individuals to want to follow them rather than using their clout to force conformity. Johns stated that while some people have innate leadership qualities which are easily cultivated; others have to learn and adopt these qualities. Also, while not all managers are leaders, all leaders are managers, and leaders are present and can function at every level within an organisation. However, for an organisation to benefit from leadership, the process must be effective. This requires stakeholders being proactive and appropriately equipped to participate in valuable decision making, thus, effective leadership is visionary leadership. It helps to strengthen relationships, build trust, foster innovativeness, encourage commitment, challenge the status quo, and build competencies (Johns, 2002).

Although myriad descriptions exist for leadership, there is no agreed definition. Daft and Marcic (2012) described leadership as “the ability to influence people toward the attainment of goals” (p. 12). This might not have been an agreeable definition but these authors further elucidated that leadership is a people-oriented activity that is shared and that leadership role models are diverse. Other management gurus, Cole and Kelly (2011), labelled leadership as a process used to persuade others to identify needs and to agree about the adoption of appropriate methods to meet those needs while facilitating individual and communal efforts to accomplish agreed objectives. However, one HIM specialist offered that leadership is the “motivation and inspiration of the organisation’s managers and staff to achieve its mission and strategic goals and



fulfil its ethical principles and moral philosophy” (Johns, 2002, p. 727). Regardless of the definition one prefers, the researcher agrees with Miller (2013b) that leadership is a contested issue.

Leadership is fast changing and developing. In the last decade, there seem to be much emphasis on leadership in organisations especially in relation to building competencies for personal development and improved organisational outcomes. Harris and Spillane (2008) shared that in recent years researchers have dedicated significant amount of attention to educational leadership but organisational leadership is better effected using a collaborative approach and recognising individuals for their efforts. It is therefore important to understand that leadership is not the “possession” of managers; neither is leadership owned only by senior managers in organisations (Hill-Berry, 2015). Instead, leadership is a shared function that requires participation from various stakeholders. The essence of shared leadership is creating opportunities and implementing strategies to incorporate stakeholder participation in the process (Johns, 2002); and to address leadership challenges while building capacity in potential leaders (Smith, 2013). In congruence with this leadership for capacity building, the Maryland State Department of Education (2006) designated prospective leaders as those individuals who are not yet identified as leaders but have the potential to become successful leaders and will do so if they are given such opportunities.

In many organisations, leadership roles are not rotated and only a few staff members get an opportunity to develop leadership competencies and skills. Notwithstanding, there are myriad activities in institutions that create leadership opportunities, and with professional development some people are positioned to assume leadership roles (McCallum, 2013). When they do, some hold on to these positions until they are promoted or separated from the organisation. But

according to Bostanci (2013), this does not have to be so because leadership can be shared to empower people and boost their effectiveness. Meanwhile, except for years of service resulting in promotion to a position of responsibility, an individual may be in one position and in one department for years with very little or no hope of being promoted. In instances where leadership roles are not rotated, they may never get an opportunity to participate in leadership activities until they are promoted (McCallum, 2013).

As Othman and Sumardi (2013) opined, organisations identify and develop future leaders to ensure a smooth succession for important positions. However, according to the Maryland State Department of Education (2006) “leadership succession is an issue everywhere” (p. 1); and effective strategies should be co-opted to address these issues and to identify leadership candidates and develop them for effective leadership which is one of the springboards of successful organisations. Too often organisations fail because those appointed to lead them do not possess the knowledge, skills, competencies or even the experiences required to effectively execute their roles (Miller, 2014). However, effective leadership means that those who are appointed in such roles are clearly identified as the most appropriate persons to lead.

### **3.5 Current leadership practices**

Leadership, as contended by DeVry University (2013), involves investigating various types of situations and developing strategies to provide guidance and facilitate camaraderie to build an environment that fosters quality teaching and learning. Miller (2013b) argued that current leadership practices should be guiding individuals to desired outcomes; setting directions for individuals, groups and organisations; and influencing them to follow pathways that lead to desired outcomes. In today’s environment, in the HIM sector, there is somewhat of a

constriction in the market for leaders and leadership seems to be a position and a possession for senior managers only (Heritage, 2011). This may be so because although the younger generations seem to desire knowledge instantaneously, they are deprived of the related practical experiences and in some instances, very few of them are aspiring for leadership (Rubenstein, 2014).

According to Hill-Berry (2015), “leadership is an important ingredient in the recipe for building competencies and ensuring organisational effectiveness but there are several challenges to leadership” (p. 7). Considering these challenges, one could understand why in recent years, leadership discussions are geared toward adopting approaches that are comprehensive and participative in nature and practice (Egbo, 2005). A proposal made by Corson (2000) was that managers change their attention from protecting personal interests and instead adopt an emancipatory approach which could help to foster participation and sharing in organisations. However, Harris (2008) recommended adopting a distributed leadership approach to provide leadership to particular groups or organisations. In a distributed leadership environment, according to Greenfield, Braithwaite, Pawsey, Johnson, and Robinson (2009), parties are interacting and sharing expertise which lead to learning while building capacity and fostering synergy. Therefore, as Talan (2010) suggested, distributed leadership can help to improve leadership practices and allow for commitment to driving initiatives.

These types of shared leadership seem to be agreeable channels and effective strategies in succession planning in which people who are not usually in leadership positions are allowed to participate in leadership activities while being prepared to take on leadership roles. Considering the nature of HIM, these attributes of leadership are essential in executing the various processes.

However, for one to appreciate this study, is important for them to have an understanding of what health information management is about.

### **3.6 Health Information Management**

Health information management practitioners, according to Sharma and Gopalkumar (2017), are “custodians of data and information within a healthcare setting” (p. 14). HIM practitioners perform several functions that are crucial to health care delivery. They understand the processes required to manage the HIM landscape – from record creation to record disposal – and through their practice they perform roles critical to patient care continuity and health planning and delivery (Gibson, Abrams, & Crook, 2015). Because of these critical functions, Zeng, Reynolds, and Sharp (2009) described HIM practitioners as custodians and managers of health data and health information; while the HIM department is considered to be the core of any health institution (Huffman, 1994; Johns, 2007).

According to HIM gurus, Huffman (1994) and Johns (2007), the above functions make HIM practitioners custodians for the accuracy, completeness, security, and availability of patients’ health information and other health data; and the HIM department requires proper management if it must effectively discharge these functions. Additionally, enthusiastic and dedicated workers are needed for the HIM department to realise success. Therefore, all practitioners must work together to evaluate the processes and initiate steps for organisational improvement and personal development in order to keep pace with developing HIM trends and the rapid changes in the healthcare environment (Roberts, 2007).

Similar to other medical ethics, the HIM profession is guided by its code of ethics that is underpinned by a section of the Oath of Hippocrates which states: “Whatever, in connection with

my professional practice or not in connection with it, I see or hear, in the life of men, which might not be spoken of abroad, I will not divulge, as reckoning should be kept secret” (Huffman, 1994, p. 36). Regardless of the nation or association, the HIM code of ethics sends basically the same message. However, a country or an HIM association may opt to tweak the wording to suit their particular context. Jamaica’s code of ethics borrows from this oath and encapsulates three simple but profound statements to guide the behaviour and ethical conduct of HIM practitioners in Jamaica. It states that the HIM practitioners should:

Avoid encroachment on the professional responsibilities of the medical and other paramedical professions, and under no circumstance assume or give the appearance of assuming the right to make determination in a professional area outside the scope of his/her responsibilities. Strive to advance the knowledge and practice of Health Record Science, including continued self-improvement in order to contribute to the best possible health care.

- Participate appropriately in developing and strengthening professional manpower and in representing the profession to the public.
- Discharge honorably the responsibilities of any Association post to which appointed or elected, and preserve the confidentiality of any privileged information made known to him in his capacity.
- State truthfully and accurately his credentials, professional education, and experiences in any official transaction with the Jamaica Medical Records Association and with any employer or prospective employer (Ministry of Health, 2000).

As cautioned by the Canadian Health Information Management Association (2008), while these ethical principles do not guarantee standards of excellence or professional conduct, they do

help to modify behaviours of HIM practitioners; and are most appropriate in this era of rapid HIM changes and developments. These recent rapid changes are quite evident as “the HIM profession is evolving with new and exciting careers emerging that didn’t exist just a few years ago” (Abrams, Giannangelo & Schneider, 2014, p. 35). In other words, as Schaeffer and Rouse (2014) argued, HIM practitioners serve patients and the medical community by managing, analysing, and utilising health information; and there is a growing need for HIM practitioners.

Even more than previously practiced, HIM practitioners now perform critical roles using personal and other health data, therefore individuals executing these roles must be trained (WHO, 2013). It was this very position that HIM pioneers shared decades ago and have thus dedicated their work to advance the profession through leadership and education (Huffman, 1994).

With the broadening of HIM careers, Johns (2007) noted that these positions are not necessarily in the usual health facilities. Instead, several new positions are created in other industries that are involved in health systems development and health data management. Because of the unique capabilities and skills owned by HIM professionals, they are on the cutting edge of a successful profession; and significant changes in HIM are expected in the ensuing years. In order to meet the new and growing demands accompanied by these expected changes in data needs and employers’ demands, HIM practitioners must ensure personal and professional development; hence they are encouraged to pursue continuing education and lifelong learning. With this in mind, a number of strategies are being adopted such as new programmes and new careers are also being introduced (Roberts, 2007).

According to Stoltz (2013), introduction of new HIM related careers and the move toward electronic health record carry with them a growing need for HIM practitioners to address these

demands by pursuing continuing education. The reengineering and widening of the HIM profession continues to result in the need for personal and professional development. Developing these competencies means creating opportunities for more rigorous knowledge-sharing, researching and publishing on this vital matter of HIM; and as much as possible sharing the information to build one another and to improve practice. As Abrams, Giannangelo and Schneider (2014) noted, “through mentoring and train-the-trainer approach, HIM professionals can practice leadership skills by helping entry level staff gain competencies” (pp. 37-38). Health information management education continues to flourish and as the need for HIM professional grows, this programme is growing in popularity (Schaeffer & Rouse, 2014). Additionally, as competencies continue to develop; myriad opportunities are being created to share knowledge by participating in research and publication on the subject (Abrams, Giannangelo & Schneider, 2014). This requires the support of HIM practitioners who are willing to assume the role of leadership.

### **3.7 Leadership in Health Information Management**

Huffman (1994) argued that leadership is oftentimes seen as an important characteristic of management that is about wielding power and influencing others to achieve established goals. Huffman further argued that leaders do wield different types of power but the sources of such power are varied; and are usually determinants of leaders’ effectiveness in terms of management and leadership. Effective leadership therefore involves a balance in interests – that is, interest in both employees and organisational outcomes (Huffman, 1994). As earlier stated, leadership is a people-centred activity that is shared; and this means incorporating leadership styles from

various sources and developing minds while sharing the weight that is placed on one or a few individuals (Daft & Marcic, 2012).

This sharing could be realised through systems thinking since “to change organizations and systems will require leaders to get experience in linking to other parts of the system. These leaders in turn must help develop other leaders with similar characteristics” (Fullan, 2004, p. 9). Here, HIM leaders who embrace systems thinking would take on a variety of roles and responsibilities that could bud into system-wide improvements through their efforts to develop other leaders (Hopkins & Higham, 2007). Thereafter, if HIM systems are to be changed, all levels of leadership must be actively engaged. Additionally, HIM practitioners must commit to learning from and with one another, and serving with a moral purpose which could result in increased worth within their organisations and the wider practice (Fullan, 2004). A result of this could be more involvement of HIM leaders in setting directions for organisations, managing the talents within organisations, teaching and developing others, building capacities for leadership in the wider system, and ultimately transforming organisations (Hopkins & Higham, 2007); and since “current and future leaders learn in context . . . , shared ideas and commitment are simultaneously being cultivated” (Fullan, 2004, p. 15).

The notion of sharing and developing others is embedded in the Canadian Health Information Management Association’s code of ethics which speaks to leadership, innovation, and mentorship as avenues for supporting and developing others to build the profession (CHIMA, 2008). Through mentoring and information sharing, HIM practitioners also have the opportunity to personally develop leadership skills and help to harness leadership competencies in others (Abrams, Giannangelo & Schneider, 2014).



Practicing leadership in HIM is important to leadership development. Over three decades ago Schatz (1997) cautioned that while classroom learning is good, the results would be fruitless except there is active engagement in related leadership activities. Hence, the vital process of leading HIM requires keen understanding, commitment to the process and creativity to engage different strategies at every level toward the desired outcome which is to “make them better at what they do, for the benefit of an organisation and its clients” (Miller, 2016, p. 101). Similar to other disciplines, in HIM, leadership is most often connected with senior managers but this is truly a misconception since especially in successful organisations leadership is demonstrated at every level (Fuller, 2002). Hence, in HIM leadership, the focus should not be on senior management leadership; rather, on “people leadership” (Miller, 2016, p. 99).

Specific emphasis is now being placed on leadership in HIM to the point where international tertiary institutions are offering professional certification programmes in leadership in health information technology. The University of Minnesota (2014) shared that through this certification programme, individuals will develop the capacity to successfully lead HIM operations and use health information technology to bring about changes and improvements in the quality of the outcomes in health service delivery. Hunt (2014) also posited that increasingly, there are discussions around the issue of leadership in HIM and in like manner, there is growing need for HIM leadership, and these positions are best led by HIM practitioners. However, if certified HIM practitioners do not grasp these leadership opportunities, then practitioners in other disciplines will and the results will not be as effective.

According to Sheridan, Watzlaf and Fox (2016) leadership training in the HIM profession is a matter in earnest, and this training should assume formal and informal approaches. HIM leadership training should address their perception of themselves as leaders, how leaders within

the discipline develop, their deportment during work, and the way these practitioners manage and lead. In addition, leadership development initiatives should be designed to help individuals to personally develop. These initiatives should also allow for the provision of the right tools and strategies to address any barriers to leadership (Johns, 2013).

Learning leadership by doing leadership can be an effective tool for leadership development and if used appropriately, this method can deliver desirable outcomes which could be revealed in enhanced team spirit and leadership qualities. If this learning-by-doing approach is embraced throughout the HIM profession, it can be used to teach practitioners how to become leaders, and to teach those who are managers how to also be leaders (Troupe, 2010). Sheridan, Watzlaf and Fox (2016) expanded that varied training methods should be employed including volunteering in related professional associations/organisations, self-training by reading leadership materials, participating in leadership seminars and workshops, sharing leadership experiences, enrolling in academic programmes, as well as HIM professionals using whatever leadership resources are available to them.

On the issue of leading and managing change within the HIM profession, Strachan (2009) put forward that “whether you manage an operational/project team or are a team member, HIM practitioners must learn to be ‘transformational leaders’ and be prepared to work beyond organisational bureaucracy” (p. 9). Strachan further informed that there are a number of opportunities for leaders who are prepared to ensure their workplaces and the services they provide are transformed to meet the changing HIM work environment that attract scarce talents and retain employees for very long employment periods.

### **3.8 Recruitment, retention and succession planning in HIM in Jamaica**

**3.8.1 Recruitment.** Fuller (2007) defines recruitment as “the process of finding, soliciting, and attracting employees” (p. 893) for an organisation; while Daft (2010) describes recruitment as “activities or practices that define the characteristics of applicants to whom selection procedures are ultimately applied” (p. 318). This talent acquisition process is a detailed one which involves developing job descriptions, determining particular positions that should be filled, advertising these positions, scrutinising applications ... and selecting the best talents (McWay, 2014). However, according to Fuller (2007), an “understanding of the organization’s recruitment and selection policies” (p. 893) is vital before embarking on the process. Recruitment must be based on merits and free from any form of political, religious, or social connections and affiliations (Miller; 2013a). In Jamaica, Duffus (2017) found that although there was a longstanding need to recruit suitably qualified practitioners, for years, public institutions have experienced a number of challenges related to recruitment of record management practitioners. This was so for two reasons. First, because it was difficult to identify personnel with the skills and competencies required for these positions; and second, because of unavailability of posts for staff appointment. This finding is a fitting description of the current situation in HIM in Jamaica.

**3.8.2 Retention.** Retention described by Fuller (2007) is “the ability to keep valuable employees from seeking employment elsewhere” (p. 893). Since retention is usually associated with employee morale, initiatives that promote employee personal commitment, professionalism, professional development, and high staff morale, are crucial to staff retention in organisations (McWay, 2014; Rothwell, 2010). Fuller noted that because employees change jobs, retire, or separate from organisations for various reasons, it is usual to have staff turnover; thus,

organisations should seek to retain employees and for any organisation, “retention is important for the simple reason that turnover is expensive” (Rothwell, 2010, p. 299). Therefore, “with so much effort, time, and money invested in hiring, orienting, and training an individual, it is in an organisation’s best interest to take steps to keep the individual on staff” (McWay, 2014, p. 365).

At times, organisations are reluctant or unable to promote from within. Such inhibitions also pose serious threats to retention as employees who get no opportunity for upward mobility within their organisations may get discouraged and are less likely to stay. In such instances, when looking for upward mobility, those employees are more likely seek opportunities outside their organisation (Bozer, Kuna, & Santora, 2015). Therefore, careful considerations must be given to employees’ opportunities for upward mobility, organisational policies and whether they support continuing education for employees, as well as the working conditions and the working environment (Fuller, 2007). But, “formal succession planning supported by organizational leadership development engagement can ensure talent retention and decrease burnout—and as a result reduce staff turnover” (Bozer, Kuna, & Santora, 2015, p. 505). Therefore, efforts must be expended to ensure suitable work environment as working in an environment that encourages practice consistent with professional standards could help to promote retention (Spence Laschinger, Leiter, Day, & Gilin, 2009).

According to Rothwell (2010), “employee retention is a key component of an effective organizational talent management strategy” (p. 306). Several factors, including leadership effectiveness, or lack of same, lead to retention issues. As retention issues affect the availability of talents, they continue to negatively affect organisational performance and targets. Besides, employee turnover is costly as organisations would have invested much in talent search and talent development. Thus organisations can benefit significantly from reducing turnover rates

(Melvin, 2011); and embarking on “successful recruitment strategies including ‘growing your own’ as the number one method of recruiting and retaining ... and providing quality professional development” (Wood, Finch, & Mirecki, 2013).

Additionally, organisations should engage in proper leadership development initiatives to assist them in recruitment and retention and in due course position the organisation to select the best candidates who will move the organisation forward (Bozer, Kuna & Santora, 2015).

Jamaica has long struggled with recruitment and retention issues. According to Tindigarukayo (2004), the public sector has been criticised for its inflexible recruitment policies and its inability to attract and retain suitable talents for positions of leadership and management. To address these and other related issues, Tindigarukayo recommended that the Jamaican administration implement training initiatives for public sector employees and “bonus programmes for retention of key personnel” (p. 106). Coupled with this recommendation, HIM organisations can create the sort of capacity building environment where practitioners learn leadership by doing leadership (Nixon, 2003); and this could be a positive step toward leadership succession planning.

**3.8.3 Succession planning.** Succession planning involves capacity building and professional development. It is equipping employees to fulfill key roles when the most experienced and talented people are separated from the organisation. The process involves varied training and development initiatives which can cost an organisation up to billions of dollars (Fuller, 2007; Rothwell, 2010). Succession planning is forecasting for the right mix of personnel, in terms of the right number, right type and right mix of talents, while identifying and preparing others for personal development and for assuming leadership roles or replacing leaders and meeting the organisation’s needs overtime (Rothwell, 2010). This process is about empowering all staff

members to hone their leadership skills and acknowledge themselves as essential to the leadership processes in their institutions (Ontario Ministry of Education, 2009). Such encouragement reinforces preparation to assume leadership positions; and ensures adequate number of equipped individuals by facilitating and coaching aspiring leaders to enhance their personal development and assume leadership roles (Heritage, 2011).

Succession planning requires having a team of leaders who would identify key positions for which succession planning should be done, initiate the creation of those succession plans, and engage the process of identifying and training prospective candidates as successors for those positions (Ellinger, Trapskin, Black, Kotis, & Alexander, 2014). HIM organisations should initiate continuing education and training strategies to ensure practitioners are equipped with practical skills required to function effectively and to assume new roles; also to ensure active and continuous succession planning for the HIM workforce, and currency and relevance of HIM talents and skills (Strachan, 2009).

An examination of the evolving HIM roles has demonstrated the need to engage in active succession planning for the next generation of HIM practitioners (Cooper, 2009). This need “is driven by the rate of change in healthcare, the introduction of new technology in the workplace, and the increased demand on maximising productivity” (Fuller, 2007, p. 900). One strategy is helping to identify employees with the interest and capacity for upward mobility in the organisation following which recommendations can be made for capacity building and leadership development and or promotion to leadership positions (Nugent, 2008).

HIM organisations stand to benefit if they put strategies in place to develop the talent of individuals who already are a part of those organisations and are familiar with the organisational processes (Olson, 2008). This internal talent development would ensure the right mix of talents

and pool of leaders who are prepared to assume the roles when others separate from the organisations (Pinnix, 2015). Additionally, it is wise human resource management for organisations to identify existing skills and seek to harness those skills even while seeking to build capacities and enhance professional development (Miller, 2014).

In several organisations in the Jamaican setting, there is somewhat of a “holding on to leadership” and this is detrimental to the succession planning process (Hill-Berry, 2015). Therefore practitioners are challenged to adhere to their professional code of conduct, and to continue to heighten their succession planning through various means (Hill-Berry, 2016). Some institutions, even in the Caribbean context, while not engaged in formal succession planning, do have leadership training and other professional development support systems in place (McLean, Scale, & Rouse-Jones, 2016). Other Jamaican organisations can adopt similar practices as they continue to enhance their employees’ personal and professional development. Thus, there should be planned training and development activities to prepare them so they could assume both followership and leadership roles (Green, 2011). In addition, organisations should proactively put structures and systems in place to synchronise succession planning and leadership development (Bozer, Kuna & Santora, 2015).

### **3.9 HIM training and practice in Jamaica**

As noted in Chapter 1 and in the beginning of this Chapter, in Jamaica, as in the wider context, HIM is taught in two ways – informally as an apprenticeship programme in health facilities; and formally through an approved and accredited course of study in a university (Lewis, 2012; University of Technology, Jamaica, 2013). Embedded in the formal curriculum are two practical components: one where students are introduced to the HIM departments

through directed practice; and the other where after successful completion of all other academic modules, students are placed in a HIM department where they apply theory to practice (University of Technology, Jamaica, 2013). Because of the nature of this training and practice, HIM in Jamaica entails a hybrid of learning by doing, and interest convergence intertwined with a tint of systems thinking through multiple leadership styles.

The ‘learning HIM by doing HIM’ approach allows learning to be also practical, not just theoretical; and this is an effective strategy to ensure that training is transferred to those it is intended to reach (Webb, 2006). Keeton (1983) underscored the relationship between theory and practice as through practical experiences, learners are directly engaging and interacting with the phenomenon being studied and those practical experiences result in more effective learning. As a result, the best learning is underpinned by experiential learning. Learning HIM by doing HIM also helps those participating in the process to better retain and subsequently apply what they have learnt. This is also excellent reinforcement since “the most memorable way to learn is through experience: learning by doing” (Schank, Berman, & Macpherson, 2013, p.172). Here, HIM practitioners engage in experiences that help to broaden their awareness and association by engaging (with objects, people, practices); and this allows them to uncover their potential, deepen their understanding, and create more opportunities for themselves (Lavery, 2016) while fostering a learning community.

This learning by doing community in HIM allows for application of learnt theory, and for engagement within that environment to garner professional knowledge, attitudes, and practices (Trowers, 2016). Here, practitioners’ activities and practical experiences are means through which they are educated (Rather, 2004). HIM practitioners are placed in positions to interface with real-life problems and practical situations to allow them to think critically and to problem-



solve. Additionally, since theory is being translated into practice, leadership is being learnt by engaging and creating an environment where HIM practitioners are learning leadership by doing leadership (Nixon, 2003). This environment that is constantly engaged in learning by doing could ultimately transform the organisation into one that embraces Senge's (1990) 'learning organization' where "people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together" (p. 3).

Learning by doing synchronises well with distributed and systems leadership. As described in Chapter 2, with distributed leadership, leadership is shared and practiced among individuals in an organisation and involves more interaction of individuals where a group of individuals who hone specific abilities merge those abilities to provide leadership within their groups or organisations (Harris, 2008). Considering the nature of HIM practice, pockets of distributed and systems leadership are being incorporated in its transactions. An air of systems leadership is also being practiced through "sharing of expertise, facilities and resources ..., innovation and creativity, leadership and management, vocational education and skills support" (Hopkins & Higham, 2007, p. 163). In the HIM context, more systems thinking can be put into action because it emphasises looking at the organisation as a whole; and it provides one with a wider knowledge of what is happening within that organisation (Krishnamurthy, 2013); and as systems thinking is considered to be practical at any time and in varied settings, it could also be better applied in HIM using different methods (Haines, 2016).

In Jamaica, HIM training is at times accessed by practitioners giving up one benefit (vacation leave or doubling up efforts) to gain another (study leave for formal training). This is a sort of interest-convergence where there is some negotiating and HIM practitioners give up something

in order that interests may converge (Milner, 2008). Interest-convergence focuses on internal and external processes responsible for distribution of interests, initiatives to address equity in the distribution of interests, and the allocation of social resources. It focuses on how resources are distributed, who gets certain privileges and advantages (such as study leave to pursue HIM courses), and why the recipients get those advantages over others; if a recipient continues to benefit from a particular resource, why they continue to do so and even whether there had been certain patterns in the distribution of these resources/advantages (Donnor, 2005).

Bell (2009) explained that interests can converge even in environments where it may seem unlikely; while Rashid (2016) asserted that “interest convergence may align the interest of managers with that of shareholders” (p. 619). However, the process requires shared understanding and the need to engage in explicit discourses about shared mission in the early stage of collaborative processes (Morrison, 2018). Bearce and Bondanella (2007) found that unstructured intergovernmental organisations showed no effect in promoting interest convergence. However, similar to how Bell (2009) explained it, there is at times interest convergence in HIM training, leadership, and practice in Jamaica. For example, although HIM policy, practice and academic leaders have differing interests in various programmes and initiatives, they at times consider what it would be worth to redirect their efforts to leading, managing, and training in HIM, give up their preferences for other initiatives, converge their interests and pool resources toward enhanced leading, managing and training in HIM.

### **3.10 HIM Policies and Procedures**

**3.10.1 Policies.** A policy is “a decision-making guide that establishes the parameters for taking action and meeting objectives [and] establishes boundaries or limitations on the direction

the organization will take in the future” (McWay, 2014, p. 326). According to Fuller (2007), policies are important tools that may be used in organisations to ensure clarity, standardisation, equity, and consistent work quality. Miller (2018) labelled policies as “roadmaps” giving “shape and structure” (p. 45) to the systems within an organisation. Describing policies and their roles in the English and Caribbean context, Miller (2016) argued that policies are the “fuel” and “roadmaps” that propel organisational processes, establish the boundaries in which to operate, and direct the activities within organisations.

Policies should be inclusive and be clearly stated, accord with related laws, and must be comprehensive enough to reflect actual practice. Considering the sensitive nature of the HIM practice, such clarity and comprehensiveness are even more warranted while leading HIM practitioners (Fuller, 2007). In this growing HIM era, with all its complexities and interrelatedness, contribution to these policies is required from different stakeholders and should impact wider organisational processes thus the “governance policies and principles must be inspired by systems thinking” (Krishnamurthy, 2013, p. 205). Because policies may be used in lawsuits, they should be carefully developed (Fuller, 2007) to communicate standard organisational processes to guide employees’ actions, as this will help to increase performance levels for employees and ultimately the organisation. Therefore, organisations need to invest in on-the-job training to appropriately orient employees to these policies while developing employees’ skill sets (Mishra & Smyth, 2015).

**3.10.2 Procedures.** McWay (2014) described a procedure as “a series of interrelated steps that are documented and used to provide standardization to routine tasks or problems” (p. 326). These instructions ensure high-quality, desirable outcomes of tasks and initiatives undertaken, and specify how work should be done and how policies should be applied (Fuller, 2007). In

organisations, procedures “provide the necessary detail for meeting one aspect of an objective or goal” (McWay, 2014, p. 326). Because of the delicate nature of HIM transactions, the practice requires clearly outlined procedures to guide practitioners’ actions. Once these are clearly communicated, practitioners can engage in practical learning by following these procedures. A learning-by-doing approach to implementing these procedures is an effective strategy to ensure that HIM practitioners continue to interact with, and adhere to established operating procedures in their department (Webb, 2006).

In Jamaica, the policies and procedures guiding the HIM practice are set out in the *Procedures Manual - Health Records Services* (Ministry of Health, 2002). However, the need exists for relevant and current policies and procedures to help “establish the overall context of [HIM institutions] and to provide a framework within and through which [these institutional] leaders perform their duties” (Miller 2018, p. 20). HIM practitioners are equipped to contribute to policy development and because of the key roles that HIM practitioners play, their expertise is advantageous to address policies and procedures in information management processes, and they need to be the leaders in such processes (Gibson, Abrams, & Crook, 2015).

### **3.11 Chapter summary**

It is clear that HIM organisations desire effective leadership and management; collaborative types of leadership seem to be the response to identified leadership gaps; emphasis is now being placed on leadership in HIM; and capacities must be developed to enhance leadership in HIM. Additionally, careful analyses of HIM training and practice and an overhaul of policies and procedures in organisations are warranted to inform HIM practice and decision-making in organisations teaching, managing and leading HIM.

## **Chapter 4 - Research Methods and Design**

### **4.1 Philosophical Stance**

The philosophical approach assumed in this study was pragmatism. This because it is a mixed-methods study and these studies are usually aligned to pragmatism where the researcher uses multiple methods, “different world views and different assumptions, as well as different forms of data collection and analysis” (Creswell, 2015, p. 11). Pragmatism focuses on what works best and “offers a suitable framework within which to understand leadership” (Al Zefeiti & Mohamad, 2015, p. 3). Pragmatism, according to Creswell (2014), is not keen on any one scheme of philosophy and this is what happened with this convergent-parallel mixed methods research in that the inquiries drew from both quantitative and qualitative assumptions. In addition, pragmatism was suitable for this study to explore the relationship between types of leadership - particularly between transformational leadership behaviours – and employees’ work performance (Al Zefeiti & Mohamad, 2015). The researcher was at liberty to choose the research methods and procedures that were appropriate for this study. Rather than a single method, the researcher used two different approaches for collecting and analysing data. This process entailed the researcher collecting two sets of data from participants, placing one data set into themes and making generalisations from the other, then doing a comparison with the literature in Chapter 3.

An inductive reasoning approach was used to collect data and develop ideas and explanations according to the results (Al Zefeiti & Mohamad, 2015). Inductive reasoning was done where the researcher kept analysing both data sets to identify comprehensive themes and generalisations (Creswell, 2015). The researcher then critically reviewed both data sets to determine what could

be deduced from the data and whether more data should have been collected or there was enough evidence to support each theme or generalisation (Creswell, 2014, Creswell, 2015).

## **4.2 Overview**

Research methodology is the formal process that the researcher takes to execute the research and generate the report. Research methods underpin the procedures to be followed, and dictates the actual tools that will be used in the process (Leedy & Ormrod, 2010). Though there is no prescribed method of conducting a research, a clearly specified method is important to understanding the purpose of a research design. This research methodology is important to indicate the researcher's intent, to specify the reason for conducting the research in the way intended, and to guide the researcher in terms of where to take the research. The methodology also provides guidance for those who will read the report and appropriately informs others who may be interested in replicating the study. This chapter discusses the methods used for executing this study in order to answer the research questions. This chapter is organised according to headings as follows: methodology, inclusion and exclusion criteria, research design, population, sample, data collection, procedures, pilot study, reliability and validity, data analysis, ethical issues, and timeline.

## **4.3 Methodology**

A carefully selected research design will assist in ensuring that the evidence found allows the researcher to appropriately answer the research questions. When conducting research, there are two main types of approach that researchers usually take. These are quantitative and qualitative. In this study, the researcher used a combination of both.

**4.3.1 Mixed methods research.** A mixed methods research is one in which the researcher

“gathers both quantitative (closed ended) and qualitative (open-ended) data, integrates the two, and then draws interpretation based on the combined strengths of both sets of data to understand research problems” (Creswell, 2015, p. 2). Mixed methods approaches are used in various disciplines including the behavioural, health and social sciences where the researcher has interests in both the quantitative and the qualitative types of data.

According to Leedy and Ormrod (2010), the essence of quantitative research is to focus on variables of interest in a population and make inferences to that population. Quantitative research focuses on measuring those variables through carefully designed instruments or tests. The quantitative researcher studies variables in specific situations and does some form of predictions and generalisations (Ary, Jacobs, Sorenson, & Walker, 2014). However, qualitative research focuses on methods that rely on generating descriptions from data gleaned from investigations concerning what naturally occurs in a particular setting and properly contextualising that data. A combination of these approaches was helpful to “provide a more complete picture” (Leedy & Ormrod, 2010, p. 97). Further, one method was used to strengthen the other and this also helped to enrich the findings (McWay, 2014).

Also called positivism, the quantitative approach, according to Gall, Gall, and Borg (2007), is based on the view that the researcher is independent of what is being studied and that data collection and analysis were done scientifically and objectively. As Leedy and Ormrod opined, this approach helped to position the researcher to somehow isolate from the participants and avert bias while drawing conclusions and developing generalisations that add to existing assumptions. For the purpose of this study, a cross-sectional survey research design was used to collect the quantitative data.

A qualitative approach focuses on contextualising and deriving meaning in that the investigation is usually bounded by a particular context or setting (for example, Jamaica); and the focus is on how people (such as HIM practitioners) make sense of, or interpret their experiences within that context or setting. With qualitative studies, rather than making attempts at predictions, the researcher seeks to understand the particular situation or unique context (Ary, Jacobs, Sorenson, & Walker, 2014). The qualitative data collection method used in this study was semi-structured interviews.

**4.3.2 Why a mixed method approach?** For this study, a decision was taken to use a mixed method approach because the researcher felt that due to the weaknesses of each approach mentioned above, the use of quantitative research or qualitative research alone would have been insufficient to appropriately answer the research questions. This approach, defined by Creswell (2014) as a convergent parallel mixed methods approach, allowed for combination of both quantitative and qualitative approaches throughout the study. This combination is illustrated in Figure 4.1.

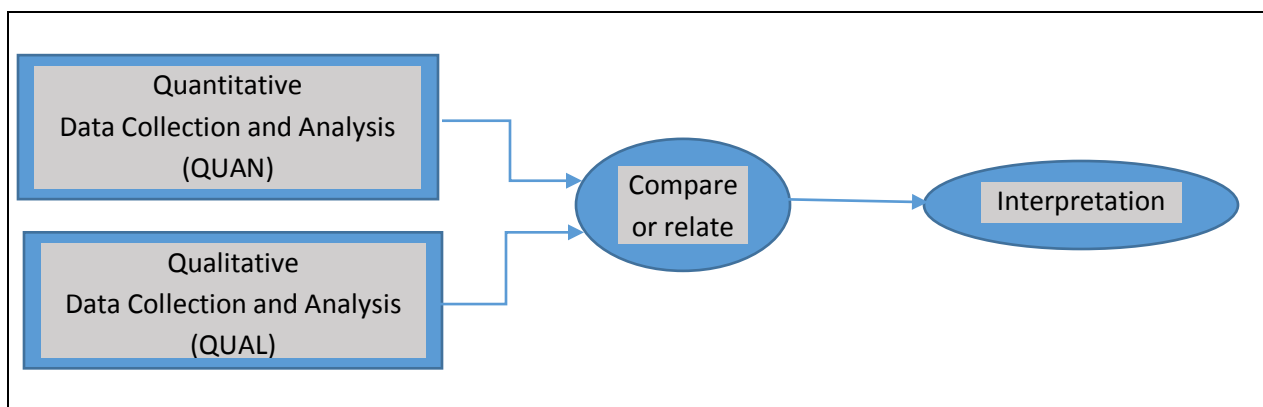


Figure 4.1: Convergent Parallel Mixed Methods (Source: Creswell, 2014)

With the convergent parallel mixed-methods approach, the central tenets are the approach to data collection, the approach to data analysis, and the approach to data interpretation. Unlike the



sequential mixed-methods approach where one type of data collection is done after the other, the convergent parallel mixed-methods approach, allowed for a combination of both quantitative and qualitative approaches throughout the study (Creswell, 2014). Data analysis was done simultaneously followed by data interpretation. As earlier stated, Jamaica is 4411 square miles, and having to travel to the 30 health facilities over the country, it was practical that the researcher use this option to maximise on resources.

In addition to the reasons outlined for each approach, this combination of approaches was used to get the views of the participants being studied and examine those views to appropriately answer the research questions (Egbo, 2005.; Leedy & Ormrod, 2010). Further, this approach was selected for two reasons - expansion and triangulation. Expansion in that both methods were used to broaden the enquiry; and triangulation to simultaneously collect both types of data, fuse the data garnered, and use the results to answer the research questions (Creswell, 2008). Also, with triangulation, one method helped to strengthen the other and was used to corroborate the findings of the other allowing the researcher to identify convergence, contradictions or consistencies. The researcher used a fully mixed approach as the integrations began at the design phase and continued at each point through to making inferences (Ary, Jacobs, Sorenson, & Walker, 2014).

#### **4.4 Inclusion and Exclusion Criteria**

Participants in the study were drawn from select public health facilities in all four health regions. This included all the public general hospitals (Types A, B, and C) and two specialists hospitals; along with the Type 4 and Type 5 health centres, as indicated in Appendix A. The specialist hospitals were included in the study as they are public facilities and a number of HIM

practitioners work in those two hospitals. Including only public health facilities meant that participants shared some common characteristics in that only practicing, full-time HIM practitioners were used in the study. The common characteristics are that participants (a) are HIM practitioners, (b) are employed full-time, and (c) are all practicing in public health facilities in Jamaica. Since the University Hospital of the West Indies is semi-private facility it was excluded. Other specialist hospitals and smaller health centres were also excluded to maximise resources and to avoid overlapping as at times the staff in the larger facilities were reassigned to “cover” in the smaller facilities.

#### **4.5 Population**

A population is a particular group of interest to a researcher (Best & Kahn, 2006); and is defined by the common characteristics that the members share. There are different types of population which are usually clarified for research purposes. Target population is the special group of interest to which the researcher intends to generalise the findings; while the accessible population is that group that will adequately represent the target population and that is convenient for the researcher to reach for the study. Participants used in this study were from selected public health institutions located across Jamaica. This includes a total of 30 health facilities, comprising 19 hospitals and 11 health centres. (See Appendix A). <sup>2</sup>The total population in the selected institutions was approximately 513 HIM practitioners (N=513). Table 4.1 details the distribution of persons in these two sub-groups and the related sample size.

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<sup>2</sup> An informal head count of HIM practitioners was done by the researcher and a senior HIM practitioner in 2016. This count revealed over 715 HIM practitioners working in the public health facilities in Jamaica; with 119 (i.e. 17%) formally trained. Of the total number of HIM practitioners, 513 were employed to Types A, B and C hospitals, types IV and V health centres, and the two main specialist hospitals. These are the facilities described in the inclusion section of this study.

Table 4.1  
*Population and Sample of Participants*

Participants	Number of Population (N)	Number in Sample (n)
Hospital HIM practitioners	418	209
Health Centre HIM practitioners	95	48
Total	513	257

**4.5.1 Selection of Participants for the Quantitative Phase.** In instances where it is not feasible to use the entire population in the study, a sample is drawn. As defined by Best and Kahn (2006), “a sample is a small proportion that is selected for observation and analysis” (p. 13). Sample sizes for mixed-methods studies vary based on the type of study and the data collection methods to be employed; but researchers are generally encouraged to use the largest sample possible. Creswell (2008) recommended that researchers use an estimate that is “based on the size needed for statistical procedures so that the sample is likely to be a good estimate of the characteristics of the population” (p. 156).

For a survey, Creswell recommended using approximately 350 participants. Notwithstanding Creswell’s recommendation, the main determinant of the sample size for this study was the size of the population. To determine the lowest sample size appropriate for this study, the Sample Size Calculator by Raosoft was used and a minimum sample size of 220 was returned. This number was obtained by using the confidence level of 95%, a five per cent margin of error, and a 50% response distribution. However, the researcher felt the need to include a wider cross section to ensure adequate representation from each health region.

Considering the need to have this representation and the possibility of non-response, 50% of the population (see footnote of page 73) was targeted as the researcher intended to get feedback from at least this recommended number of participants. Hence the targeted sample size was 257 participants ( $n = 257$ ). Leedy and Ormrod (2010) informed that the proportion of participants who return completed questionnaires is usually about 50%. In this study, the researcher targeted a minimum return rate of 85%, in order to obtain at least the minimum sample size of 220, as returned by the Raosoft Sample Size Calculator and noted above. The sample size for the pilot study was 10% of the targeted participants while the remainder of the selected participants were used in the main study. To ensure representativeness, each health region was used as a stratum. See Table 4.2 for the distribution of participants in the target population by health regions.

Table 4.2  
*Distribution of Participants by Health Region*

Health Region	Participants		Total
	Pilot	Main	
North-East	4	37	41
South-East	10	88	98
Southern	6	47	53
Western	7	58	65
Total	27	230	257

**4.5.2 Selection of Participants for the Qualitative Phase.** A total of 17 participants were targeted to be interviewed. This comprised two representatives from each of the four health regions, four directors from the Ministry of Health, and five academic leaders (drawn from the head of school, programme leaders, and members of the HIM academic advisory committee at the sole HIM academic institution in Jamaica). As this number comprised three groups (mentioned above), one participant from each group was selected for interview during the pilot and the remaining 14 were targeted for interview in the main study. Of this number, 13 were successfully interviewed.

#### **4.6 Data Collection for Quantitative Phase**

Using the methods and instruments described below, all the data collection were done mainly through face-to-face interactions; and where this was not convenient, some interviews were conducted via telephone.

***Questionnaires.*** A set of questionnaire were created for HIM practitioners currently practicing in the public health facilities across the island of Jamaica. All of the questions were specific to their work context. Using this instrument enabled the researcher to gather more information that was specific to answering the research questions. This questionnaire had three sections. Section A had six demographic items on health region, age-range, gender, number of years practicing HIM, number of HIM practitioners in the institution, and type of health institution in which practitioners worked. Each of these items had response options from which participants were required to choose from by ticking the box provided beside each option.

Developed by Rensis Likert in the 1930s, rating scales, more often referred to as Likert scales, are tools used to assess people's attitude, behaviour, opinions, or other phenomenon on a

continuum (Leedy & Ormrod, 2010). For the purpose of this study, a five point rating scale was used to measure the degree to which participants agreed or disagreed with the statements in Section B of the questionnaire. Allowance was also made for neutral points where participants were undecided about their responses (Sullivan & Artino, 2013).

Section B of the questionnaire had 35 Likert-type items. These items had the response format of strongly disagree with a value of one to strongly agree with a value of five. Section C had two open-ended items and spaces were provided for participants to write their responses to those two items. See Appendix B for a copy of the questionnaire. These instruments were administered through face-to-face surveys. This face-to-face option was used in order to capture more participants and it allowed participants who did not have email access the opportunity to take part in the study.

#### **4.7 Data Collection for Qualitative Phase**

***Interview.*** A semi-structured interview was conducted with selected HIM practice leaders in each health region, selected policy leaders in the Ministry of Health, and selected academic leaders in the training institution. This semi-structured interview allowed the researcher to “follow the standard questions with one or more individually tailored questions to get clarification or probe a person’s reasoning” (Leedy & Ormrod, 2010, p. 188). Some of the interview items were similar to the items in the questionnaire. These were so structured to enable the researcher to compare across groups the responses given to those items. An interview schedule, copy of which is shown in Appendix C, was used to guide the interviews. The interviewer at times used other probing questions to encourage interviewees to elaborate on their

responses, to clarify responses when required, and to solicit more detailed responses. Interview responses were hand-written and voice recorded.

Table 4.3  
*Summary of Research Questions and Data Collection Methods*

Research Question	Data Collection Methods
1. What leadership practices currently exists in Jamaican organisations in involved in the leadership and management of HIM?	HIM Questionnaire (Section B); Interview
2. (a) What role and impact do HIM managers have in succession planning (capacity building and professional development) and the development of the HIM profession?	HIM Questionnaire (Sections B and C) Interview
(b) How has this impact been captured and measured by internal and external stakeholders?	Interview
3. What can academic and policy leaders do to address the challenges identified regarding recruitment, retention and succession planning among HIM in Jamaica?	Interview
4. What role, if any, do external stakeholders play in the recruitment, retention and succession planning of HIM practitioners in Jamaica?	Interview
5. What policies and procedures are in place to guide HIM orientation, training and practice in Jamaica?	HIM Questionnaire (Section B); Interview

Using questionnaires along with interview enabled the researcher to gather more information that was specific to participants' perspectives and views on the subject, and helped to provide

“richness” to the data (Creswell, 2008). This helped the researcher to gather more comprehensive answers to the research questions and compare the responses provided to those items. Table 4.3 outlines the research questions and the corresponding data collection methods used.

**4.7.1 Procedures for data collection.** Attached to each questionnaire was a statement reminding participants of the purpose of the study, addressing ethical issues, asking participants to sign the consent form as an indication that they have been properly informed and their willingness to take part in the study, and providing instructions on how to complete the questionnaires should they decide to participate. See Appendix D. In relation to the interviews, a similar approach was taken. Prior to the interviews, the purpose of study was explained to the participants (via email and telephones calls) within a reasonable time frame to allow for informed decision making and scheduling of appointment for interviews. By doing this, participants were positioned to better understand their role in the study, as well as the reason it was important for them to take part. The researcher believes this also helped to gain commitment and it also increased the response rate. Questionnaires were administered and the interviews conducted concurrently (during the same period). This concurrent data collection helped to lower costs for travelling and to maximise the use of time and other resources.

## **4.8 Pilot Testing**

It was important to test the research instruments before using them for the main study (Leedy & Ormrod, 2010). Pilot testing enabled the researcher to determine the extent to which “individuals in the sample are capable of completing the survey and that they can understand the questions” (Creswell, 2008, p. 402). As Leedy and Ormrod advanced, pilot study also helped the



researcher to determine the feasibility of the study. Using 10% of the targeted sample of the population, the questionnaire was pilot tested before it was used for the main data collection activity.

The wide location of the population was another vital reason for pilot testing the data collection instruments in order to determine how the questions were interpreted by participants in each health region. The pilot testing exercise was done during the months of May and June, 2017. During the exercise, participants were asked to read and respond to the items in the questionnaire, and to comment on the quality of the items. Participants were asked to note the time it took to complete the questionnaire and any problems on the survey instrument, such as clarity and wording of the questions (Creswell, 2008). In accordance with the feedback from participants, the questionnaire items were revised before using them in the main study.

*Questionnaire piloting.* Participants in the pilot survey reported that the items on the questionnaire were clear and that they felt their colleagues should have no problem answering the questions. However, the questions that participants posed, and their feedback suggested that to solicit specific responses in the main study, minor adjustments to the items on the questionnaire were warranted. For example, the heading for the first category of questions in Section B read, “*Leadership in my institution*”. This, the researcher had to clarify while administering the questionnaire. Subsequently, that heading was changed to read “*Leadership in my department*”. The researcher also noted minor changes to be made to questions 28, 31 and 33. Although not reported by any of the participants, the researcher noted two omissions from the response options on the questionnaire. In relation to the third question in the demographic data section of the questionnaire, the 21 – 25 category was omitted, and two other options

needed minor edits. Subsequently, this new category was entered on the adjusted instrument, resulting in seven options from which participants selected one.

Another question, the fifth item, had nine options. However, the researcher further removed the first three options as the survey excluded participants from those facilities (Types 1-3 health centres). The other change was made to the final closed-ended question which read “*the HIM policies are current and relevant to the practice*”. This item elicited two-part answers and so the researcher edited that item and generated two questions – one focused on currency while the other focused on relevance. (See Appendix B). Some participants did not readily understand the term *succession planning* and the researcher had to explain it. Otherwise, participants reported that the questions were “pretty straightforward”, “reasonable”, “clear”, “understandable”, and “easy to answer”. One participant reportedly found the exercise “intriguing”.

*Interview schedule piloting.* The interview schedule was piloted in a similar manner and where necessary, adjustments were made based on the feedback received. The interview schedule was also piloted to determine how well participants understood the questions, the usefulness of the instrument, and to assess their relevance to the target population (Crosby, DiClemente, & Salazar, 2006). It was while interviewing that the researcher realised the final question was omitted from the interview schedule. The question was however posed and subsequently added to the schedule. (See #13 on the Interview Schedule in Appendix C).

#### **4.9 Reliability and Validity**

Before administering the research instruments in the main study, it was necessary to determine any effect of errors in the measurement and the areas that needed adjustment; this was ascertained through a reliability test (Leedy & Ormrod, 2010; Gay, Mills, & Airasian, 2012).

This section describes the criteria for choosing a good research instrument. This is captured under two sub-headings: reliability and validity. Each is described below.

*Reliability.* Reliability is defined as “the extent to which the instrument yields consistent results when the characteristic being measured hasn’t changed” (Leedy & Ormrod, 2010, p. 93). Creswell (2008) explained that reliability means that the “scores from an instrument are stable and consistent” (p. 169). For this study, the Cronbach’s alpha method was used to estimate the reliability of the questionnaire for both the pilot and the main study. This method was used because the questionnaires were administered once. In order to enhance reliability of the questionnaire, Leedy and Ormrod recommend several strategies such as ensuring consistency in administering the instrument and establishing specific criteria for making judgments. To ensure consistency, the instrument was self-administered. In addition, the items in section B of the questionnaire were treated as continuous variable, because the response formats ranged from strongly agree to strongly disagree (Creswell, 2008).

Pilot testing the instruments also helped the researcher to ensure consistency. The internal consistency of the items was estimated by using the Statistical Software Program for Social Sciences (SPSS), version 22. From this pilot, the Cronbach’s alpha method was used to estimate reliability of the items on the questionnaire. According to Wellington and Szczerbinski (2007), a reliability coefficient of .70 or higher is considered “acceptable” in most social science research situations. The alpha coefficient for the items on the questionnaire was .900. The result of this reliability test suggested that the instrument was reliable and the items had a high internal consistency. The decision was therefore taken to proceed with the instruments in the main study.

*Validity.* Gall, Gall, and Borg (2007), suggested that a researcher should be able to declare that the responses collected from the respondents truly represent their opinions of what the

researcher asked; and that there is the need to ensure that the content of the items represents the characteristic being measured; in this case, HIM practitioners' views on current leadership practices in their institutions; along with recruitment, retention and succession planning of HIM practitioners. Therefore, the researcher was able to justify what measure was taken to ensure the validity of the data collection instrument. In this study, content and construct validity were used.

According to Creswell (2008), content validity is the “extent to which the questions on the instrument and the scores from these questions are representative of all the possible questions that a researcher could ask about the content or skills” (p. 172). To ensure content validity, three strategies were employed. The researcher (a) used a table of specifications (see Table 4.3), to ensure that the items in the questionnaire would appropriately answer the research questions; (b) asked an expert in item construction to review the items on the questionnaire and provide comments on its comprehensiveness; and (c) asked participants in the pilot study to critique the instrument for the quality of the items. In addition, to ensure content validity of the items on both instruments, the researcher asked another senior HIM practitioner to review the items on the questionnaire and provide comments on their comprehensiveness.

*Triangulation, member checking, and respondent validation.* As a means of validating the interviews, the researcher used triangulation and member checking. Triangulation, according to Creswell (2008), is the process of validating evidence from different sources or methods of data collection in qualitative research. Triangulation is based on the premise that a single method will not solve the research problem so multiple methods should be used to collect data. This technique involves two or more methods being used to collect data on the same phenomenon; if each of those data sets share similar or close outcomes, then there is confidence. As Creswell (2016) put forward, triangulation built evidence from the different data sources - in this study,

surveys and interviews - to identify themes in the study. Triangulation facilitated validation of data through cross verification of data collected using the two methods and gave a more detailed and balanced picture of the situation (Creswell, 2008). This technique was used to analyse the research questions from two perspectives and to enhance confidence in the research findings. Triangulation also helped the researcher to produce a more accurate, credible and valid report.

Member checking, according to Creswell (2016) is a validation method in which the researcher shared the narratives with participants and asked those participants whether the researcher's capture of their narratives were accurate representations of the stories they shared. Borrowing from Creswell, following the interviews, the researcher used member checking to validate the reports. Here, the researcher asked participants to check the accuracy of the report. This was done by reading the report and asking the participants to verify whether the interpretations of the researcher were accurate and fair; and whether their responses were appropriately represented.

#### **4.10 Data Analyses**

This section gives a description of the methods that were used for data analysis and the format in which the data are presented. Since the main methods used for collecting data were questionnaire and interview, the focus here is on quantitative and qualitative data analyses.

***Approach to data analyses.*** In presenting and analysing the data, a question level analysis is used. This means, the findings are presented according to research questions. However, a thematic analysis is used to guide the discussion where the points are discussed according to the themes that emerged from the data collected.

*Quantitative data analyses.* Creswell (2008) suggested three main steps to be taken when analyzing research questionnaires. Step one: identify response rate and response bias by creating a table to record frequency and percentages. For various reasons, be it personal preference, inconvenience, unavailability, language barriers, or reasons unspecified, people may opt not to participate in a survey. However, for proper reporting, it is important to establish the response rate which is a reflection of the proportion of people who complete the survey from the sample selected to participate in the study (Fowler, 2009). Response rate, as described by Leedy and Ormrod (2010) is the proportion of participants who return the completed questionnaires and in most instances this rate is usually about 50%. Response bias describes occurrences that lead to a deviation from the truth in the responses provided during surveys or the inclination to respond a certain way because of uncertainty (Villar, 2008).

In step two, the researcher prepared and organised data for analyses; and coded the data in accordance with the established codebook. Defined by Creswell (2008), a codebook is a “list of variables or questions that indicates how the researcher will code or score responses from the instruments or checklists” (p. 184). A numeric code was assigned to each response for each item in sections A and B of the questionnaire. Nominal variables such as gender were coded as (1) for male, and (2) for female; while the close-ended items which were categorised in an ordinal scale were coded from strongly disagree (1) to strongly agree (5). See Appendix E for a copy of the codebook. After coding, the researcher entered data into SPSS (version 22).

Step three involved cleaning and accounting for missing data. According to Creswell, cleaning the data is the “process of inspecting the data for scores (or values) that are outside the accepted range” (p. 189). This was done by visually inspecting the data set to identify responses that were within the acceptable ranges, and to identify missing data. Missing data refer to spaces

that remained blank in the questionnaire because respondents did not offer answers for those items (Creswell, 2008). Where missing data were identified, a numeric value of “0” was assigned using the missing value dialog box under “variable view” in SPSS.

Step four involved selecting the right statistical tests for the analysis; conducting the analysis; and interpreting and summarising the findings.

Finally, in step five, descriptive statistics (frequencies and percentages) were computed for the demographic data, while inferential statistics were used to analyse the items in the questionnaire, which addressed the research questions.

*Qualitative data analyses.* The researcher used Taylor-Powell and Renner (2003) steps for analysing qualitative data. This involves: reading and re-reading the text to better understand the data; examining the way respondents answered each question; and placing them into categories. The researcher then looked for themes and connections; then organised the data into themes and sub-themes; and continued to write the analysis. Table 4.4 presents the data collection and analysis methods used according to the research questions.

Table 4.4  
*Summary of Research Questions and Data Analysis Methods*

Research Question	Data Analysis Methods
1. What leadership practices currently exists in Jamaican organisations in involved in the leadership and management of HIM?	Quantitative Data Analysis Qualitative Data Analysis
2. (a) What role and impact do HIM managers have in succession planning (capacity building and professional development) and the development of the HIM profession? (b) How has this impact been captured and measured by internal and external stakeholders?	Quantitative Data Analysis Qualitative Data Analysis Qualitative Data Analysis
3. What can academic and policy leaders do to address the challenges identified regarding recruitment, retention and succession planning among HIM in Jamaica?	Qualitative Data Analysis
4. What role, if any, do external stakeholders play in the recruitment, retention and succession planning of HIM practitioners in Jamaica?	Qualitative Data Analysis
5. What policies and procedures are in place to guide HIM orientation, training and practice in Jamaica?	Quantitative Data Analysis Qualitative Data Analysis



#### 4.11 Ethical Issues

Ethics in research are concerned with the moral aspects of the entire activity. According to Ary et al. (2014), and Punch (2009), ethics in research are centred on right or wrong. Although not specified by law, researchers are expected to be conscientiously ethical if they must produce credible work (Mertler & Charles, 2011). Whenever human beings are the subjects of research, one has to carefully consider the ethical implications of such investigation.

There are several ethical issues in research and these are mainly focused on protecting participants from harm, right to privacy, properly informing participants so they are able to make informed decisions about whether to participate, the researcher's honesty, and permission to conduct the research (Ary et al. 2014; Leedy & Ormrod, 2010; Punch, 2009). Other ethical issues in research are voluntary participation and informed consent, protection from harm or injury, participants' right to privacy, and honesty (Bogdan & Biklen, 2003). As these seem to be the ethical aspects of focus in most research, in this study, the researcher paid keen attention to these issues; and her positionality as an insider/outsider.

**Permission to conduct research.** Before embarking on the study, research ethical clearance was sought and received from the School's Research Integrity and Ethics Committee. The British Educational Research Association (2011) suggested that researchers seek consent from local officials. Accordingly, the researcher sought permission from the local health authorities and the Ministry of Health before venturing into data collection. See Appendix G for a copy of the letter to the Advisory Panel on Ethics and Medico-Legal Affairs. The researcher's intention was that once these directors gave permission, the participants would have been contacted. But, it was a challenge getting permission from this Advisory Panel to enter the field. Throughout this period, the principal supervisor assisted by writing directly to the Chairman of the Advisory

Panel on Ethics and Medico-Legal Affairs, since it was a real challenge ‘Getting Past the Gatekeeper’ (Miller, Kelly, & Spawls, 2013). The researcher persevered and participants agreed to take part so the researcher went ahead and collected the data.

Researchers are admonished to be just as meticulous with ethical issues in surveys as they would in any other data collection process (Bogdan & Biklen, 2003; Leedy & Ormrod, 2010). The researcher adhered to ethical guidelines and related advice. In addition, the researcher observed ethical guidelines established by BERA, in particular ensuring that participants were:

treated fairly, sensitively, with dignity, and within an ethic of respect and freedom from prejudice regardless of age, gender, sexuality, race, ethnicity, class, nationality, cultural identity, partnership status, faith, disability, political belief or any other significant difference (BERA, 2011, p. 5).

**Protection from harm.** To ensure research participants were protected, the researcher used the principle of beneficence as a guide throughout the study. “Beneficence operates in the ethical sense through the obligation to do good in all circumstances” (McWay, 2014, p. 91). The researcher focused on promoting good and ensuring no harm was done to stifle individuals or groups or the research process; and that the activity was done to increase knowledge, increase understanding, and stimulate opportunities for advancing the population of focus (Mertler & Charles, 2011). Due to the nature of the research, participants faced no form of embarrassment, they were not bombarded by any unusual distress, nor did they suffer any damage to their self-esteem. Participants were protected from physical or psychological harm since they were only required to voluntarily complete a questionnaire or respond to interview questions related to their work context (Leedy & Ormrod, 2010).

**Confidentiality and anonymity.** “The confidential and anonymous treatment of participants’ data is considered the norm for the conduct of research” (BERA, 2011, p.7); and a “researcher must keep the nature and quality of participants’ performance strictly confidential” (Leedy & Ormrod, 2010, p.102). Being cognisant of this, participants’ right to privacy was respected to ensure anonymity and confidentiality. Participants could not have been assured of anonymity when their names were known to the researcher. However, every effort was made to maintain confidentiality. The researcher was careful to present the report in such a way that participants were not identified; and the way they responded was not linked to them (Ary et al., 2014).

In order to maintain privacy and confidentiality, no names were used on the questionnaires; rather, code numbers were assigned to each. From the interviews, particular responses were described in the report, the identity of those who participated was not divulged as their correct names were not used. Instead, each participant was assigned a descriptive pseudonym (such as Academic Leader 1) as a means of ensuring anonymity, and code numbers were used as a means of tracking the information (Ary et al., 2014; Leedy & Ormrod, 2010). Additionally, data collected were properly secured so that only the researcher had access to them.

**Voluntary and informed consent.** The people recruited to participate in this research were given proper explanation regarding the nature of the study and the activities in which they would have been involved. Participants were provided with enough information regarding why their participation was important and how the data would have been captured, stored and used for research purposes. This was done so they could understand what the research was about, and voluntarily agree to participate (Ary, et al., 2014; BERA, 2011). Participants were assured that they would not have gone through any procedures or activities that would have put them at risk

to any harm. This information was vital so they could have made informed decision concerning whether to participate.

An information section, was inserted at the beginning of the questionnaire used in the survey. (See Appendix B). This section addressed participation, withdrawal, protection of participants, confidentiality, and disclosure (Mertler & Charles, 2011). The researcher also explained the nature of the study to participants and those who agreed to take part were asked to read the information sheet. See Appendices D and F. If participants read all the information on the cover letter and decided to continue to complete and submit the survey, they were asked to sign the consent form indicating that they clearly understood what the research was about and their roles in participating; and that they had willingly consented to take part (Mertler & Charles, 2011). However, as both participation and consent were voluntary, those who expressed desire to participate but did not wish to sign the consent form, were allowed to do so.

**Liberty to withdraw.** Participants in the study were informed that participation was voluntary and should they agree, they had a right to withdraw at any time without prejudice (Leedy & Ormrod, 2010). No one was pressured, forced or persuaded to be a part of the study (BERA, 2011). Participants' refusal to participate in the study was respected.

**Honesty.** In this study, the researcher was meticulous to ensure that data collected were not "fixed or "contradicted" in any way that misrepresented the actual findings/results (Mertler & Charles, 2011). Honesty was maintained to ensure that findings were truthfully represented and no one would be misled concerning the nature of the study or the findings reported (Leedy & Ormrod, 2010). As soon as the process of data collection began, the researcher began collating, coding and recording data exactly as collected (Mertler & Charles, 2011). In addition, all credits

were given where due – any thoughts, ideas, words, or materials used was appropriately, and fully acknowledged (Leedy & Ormrod, 2010).

#### **4.12 Timeline.**

Acting on the advice of Ary et.al. (2014), the researcher determined each stage of the study and the time required to complete each stage as well as the order in which each stage would have been completed. This was properly planned taking careful note of the feasibility of completing the task within the specified time frame. To ensure that the work was properly organised and targets were being met in accordance with plans; the researcher analysed each activity and estimated the time required to complete each task, then planned a schedule accordingly (Gall, Gall, & Borg, 2007).

The researcher was constantly aware that for any meaningful activity, the timeline for completion is a critical factor to be considered as it does affect the quality of work output. With this constant awareness, the researcher created a time and activity chart (see Appendix H) detailing the timeline of each activity to guide the duration of this study. In a few instances, target dates were shifted but efforts were made to meet all targets. Adhering to this timeline helped the researcher to complete tasks in tandem with estimated targets and within the specified time frame.

#### **4.13 Positionality influence on the research.**

The researcher felt that her role as “insider/outsider” has had some influence on the research, in particular, her access to, and the responses of participants, some at the researcher’s own institution. Regarding collection of the quantitative data, as “insider”, the researcher anticipated

a high degree of willingness and participation. This was done at a fairly reasonable pace and in a manner expected. However, the researcher was met with several unrelated questions and issues on the field. On occasions, the researcher had to remind the participants that the research was separate from work and offered to hear their concerns subsequent to the end of data collection. As regards the qualitative data, it was challenging securing some interview appointments, even with the researcher's own colleagues. During the interviews, there were instances when the interviewees uttered "you are the best person to answer that question" and the researcher had to be reminding them, "yes, but remember this is a research and researchers cannot answer their own research questions". At times, it was frustrating and the researcher felt as if she had to prove herself to be an "outsider"; but constantly observing the ethic, the researcher remained calm and persevered.

## **Chapter 5 - Results and Data Presentation Part 1**

### **5.1 Overview**

Using a convergent parallel mixed methods approach, five research questions were investigated through administering a cross-sectional survey and conducting semi-structured interviews. Quantitative and qualitative data were collected and analysed separately, after which the results of both were compared to provide an interpretation (Creswell, 2014). This was illustrated in Figure 4.1 in the previous chapter. This convergent parallel mixed method design focused on collecting, analysing, and mixing both quantitative and qualitative data in a single study. It was based on the premise that combining both approaches would provide for a better understanding of the research questions, than using either method alone. Thus, in this study, in order to obtain similar results from different perspectives, the researcher collected and analysed both quantitative and qualitative data as a means of using one method to enhance the other; and collecting “both forms of data using the same or parallel variables, constructs or concepts” (Creswell, 2014, p. 222).

Version 22 of SPSS was used to compute the analyses for the quantitative data collected. Cronbach Alpha was used to compute reliability analyses. Other types of analyses were done including item analyses, and assessments of normality. Subsequent to the demographic data, the findings are presented according to how they answer each research question.

### **5.2 Response Rate**

The intended sample for the survey was 230 HIM practitioners. Of this number, 212 were returned with 9 removed as ‘spoils’ either because they were incomplete or participants withdrew after starting the questionnaire. One was removed because of response bias as the

participant checked the same response option for all the items on the questionnaire (Villar, 2008). Thus the actual number of responses used in the quantitative data analysis was 202 (n = 202), returning a response rate of 88%. Regarding the qualitative data, 14 individuals were targeted for interviewees. However, it was difficult to pin down one of them. Hence, 13 interviews were successfully conducted (n = 13). Thus the response rate for interviews was 93%.

### **5.3 Demographic Characteristics of Participants**

The quantitative data were collected from participants practicing HIM and assigned to primary, secondary, and tertiary health care facilities throughout the four health regions in Jamaica - North-East (NERHA), South-East (SERHA), Southern (SRHA), and Western (WRHA). The demographic characteristics of participants in the survey were: the health region where they worked, sex, age range, years in the HIM practice, and the staff complement in their institutions.

The HIM profession in Jamaica is a female-dominated one, as such participants in the survey were 16% males and 84% females; with 17.4% of participants practicing in the primary care setting and 82.6% practicing in the secondary and tertiary levels of the health system. (See Table 5.1 for distribution of participants according to the types of health facility). It is important to note that the responses provided by male participants were similar to those offered by female participants.



Table 5.1:  
*Health facilities where HIM survey participants practiced*

Type of health facility	Number	Percentage
Type 4 H/C	25	12.4
Type 5 H/C	10	5.0
Specialist Hospital	22	11.0
Type C Hospital	73	36.0
Type B Hospital	45	22.2
Type A Hospital	27	13.4
Total	202	100

The health facilities are scattered throughout the four health regions giving a wide cross section of HIM practitioners the opportunity to participate, and allowing for greater representativeness. Although participants were distributed across all four health regions, the majority of participants (40%), were in SERHA. (See Figure 5.1). This is so because the largest health facilities are located within this region and hence the HIM staff complement is also highest in SERHA.

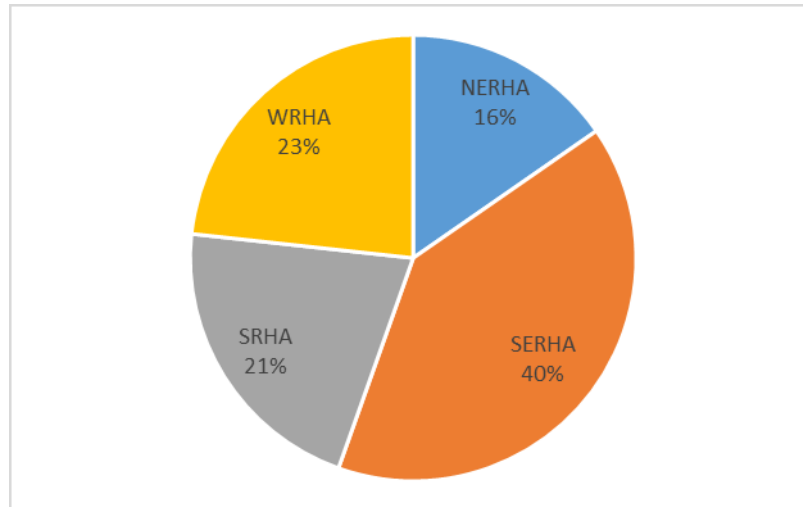


Figure 5.1: Percentage of participants according to health region

Additionally, the age of participants varied. Over 70% of participants in the survey were in between 24 – 45 years old, with majority (40%) in the 25 – 35 age range. This indicates a reasonably young HIM population. The distribution of participants according to age range is illustrated in Figure 5.2.

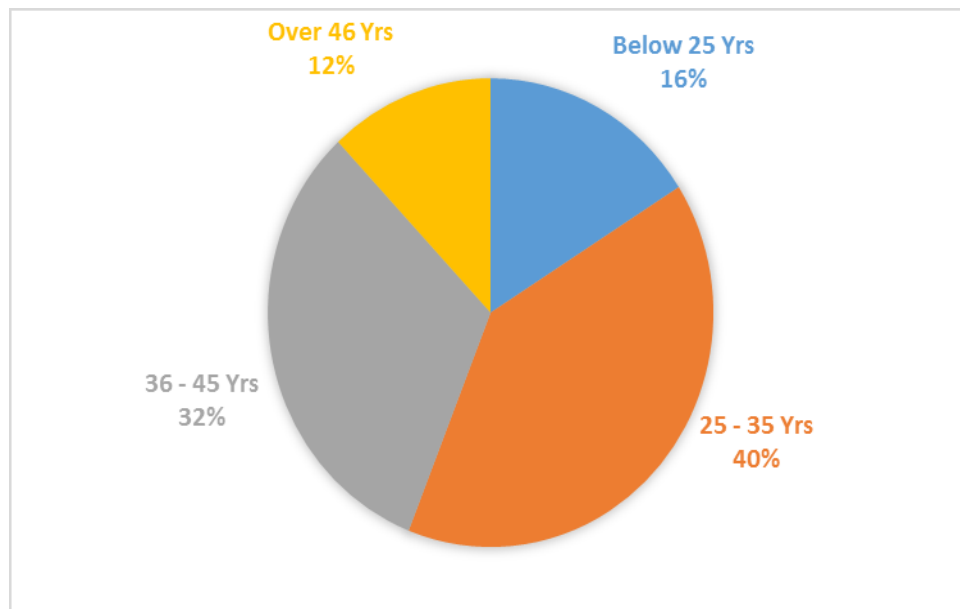


Figure 5.2: Percentage of participants according to age group

Participants' years in the HIM practice varied. This variation contributed positively to the spread, the result of which was an excellent representation of those who recently entered the profession compared to those who have been practicing for over 20 years. As presented in Table 5.2, 4% of participants were practicing for less than one year. Of the total participants, 72% reported that they have been practicing for between one and 15 years, and the remaining 24% have been HIM practitioners for over 16 years.

Table 5.2:  
*Participants' years working in HIM*

Years in HIM	Frequency	Percentage
Less than 1 year	8	4
1 – 5 years	64	32
6 – 10	47	24
11 – 15	32	16
16 – 20	22	11
Over 20	26	13
Total	202	100

This would have contributed to different experiences of each practitioner as some would have had changes in leadership and other experiences while others would not have gone through any leadership, policy or practice changes and thus were gaining fresh experiences. Also, as Table 5.3 highlights, participants did not all work with similar number of colleagues. In some institutions, participants were working with less than five HIM practitioners, while in other

institutions, as noted by 44% of participants, they were working alongside over 30 other HIM colleagues.

Table 5.3

*Number of HIM staff in facilities where participants practiced*

HIM practitioners in the facility	Number	Percentage
Less than 5	28	14
6 – 10	33	16
11 – 15	28	14
16 – 20	11	5
21 – 25	5	3
26 – 30	8	4
Over 30	89	44
Total	202	100

#### 5.4 Results of statistical tests

Using a Likert scale for items 7 - 41 (Appendix B), participants were asked to select the most suitable response to each item. These responses ranged from strongly disagree, being the lowest, to strongly agree, being the highest. Responses were abbreviated as SD (strongly disagree), D (disagree), U (undecided), A (agree), and SA (strongly agree). The scale items were organised into five sub-categories representing the headings on the questionnaire. These headings were Leadership in my department, Leadership Practices affecting HIM, Recruitment and Retention of

HIM practitioners, Succession Planning among HIM, as well as Procedures and Policies guiding the HIM practice. Data were analysed accordingly.

This section of the report provides the findings/results of the statistical analyses performed on the data collected concerning leadership, policy and practice in HIM in Jamaica. This chapter is arranged according to how the headings appeared in the literature review and the research questions. Findings have been provided based on conducting each of the following:

- Reliability analyses
- Item analyses
- Assessments of normality
- Determining differences in mean scores based on demographics

***Reliability analyses.*** Cronbach's Alpha was used to measure the internal consistency of the items on the Likert scale in terms of whether, or how closely related were the items in each sub-category. Cumulatively, Cronbach's Alpha was 0.93 which indicated a high internal consistency for all items combined. When reliability coefficient was measured according to sub-categories, Cronbach's Alpha showed a distinction between sub-categories as the result for each was slightly lower with sub-category 1 returning the highest reliability coefficient, and sub-category3 returning the lowest reliability coefficient. This may have been so because sub-category3 had fewer items and participants tended to offer similar responses to these items. Table 5.4 illustrates the results according to sub-categories.

Table 5.4:  
*Reliability measures for related sub-categories*

Sub-category	Cronbach's Alpha	Numbers of items
1 Leadership in my Department	0.902	9
2 Leadership Practices affecting HIM	0.787	6
3 Recruitment & Retention	0.625	6
4 Succession Planning	0.825	7
5 Policies affecting HIM	0.894	7

***Assessments of normality.*** Normality of the summative scores and sub-categories were assessed using the Kolmogorov-Smirnov test.

Table 5.5:  
*Assessing normality of scores*

Sub-category	P-value
Summative Scores	.200
Sub-category	
1 Leadership in my department	<.0001
2 Leadership Practices affecting HIM	<.0001
3 Recruitment & Retention	.025
4 Succession Planning	.003
5 Policies affecting HIM	<.0001

Based on the P-values provided in Table 5.5, it was concluded that at the 5% level of significance, the scores on the summative scale followed a normal distribution and thus parametric methods were validly used in the analyses of the data. Alternatively, non-parametric methods were used in the analyses of the scores for the sub-categories.

Table 5.6  
*Summary of results for tests regarding the summative score*

<b>Groups</b>	<b>N</b>	<b>P-value</b>
NERHA	31	.321
SERHA	81	
SRHA	43	
WRHA	47	
Males	32	.940
Females	169	
Below 25 years	31	.643
25 – 35 years	79	
36 – 45 years	64	
Over 46 years	25	
Less than 5 HIM staff members	28	.004
6 – 10 HIM staff members	33	
11 – 15 HIM staff members	28	
16 – 20 HIM staff members	11	
21 – 25 HIM staff members	5	
26 – 30 HIM staff members	8	
Over 30 HIM staff members	89	
Less than 1 year in HIM	8	.183
1 – 5 years in HIM	64	
6 – 10 years in HIM	47	
11 – 15 years in HIM	32	
16 – 20 years in HIM	22	
Over 20 years in HIM	26	
Type 4 H/C	25	.004
Type 5 H/C	10	
Specialist Hospital	22	
Type C Hospital	73	
Type B Hospital	45	
Type A Hospital	27	

A P-value of .004, as shown in Table 5.6, indicated that only with the two variables - HIM staff complement and type of health facility - there were differences in the responses. With all the other variables, participants responded similarly.

***Determining differences in mean scores based on demographics.*** The demographic variables under consideration included:

- Health Region
- Gender
- Age Range
- Size of HIM Staffing Complement
- Tenure in HIM Employment
- Type of Institution

For the summative score, the independent-samples t-test was used to investigate differences in the mean scores based on gender; and ANOVA was used for the other demographic variables.

For the sub-categories, the non-parametric analogues were used, specifically the Mann-Whitney and Kruskal-Wallis tests respectively.



Table 5.7  
Assessing whether disparities exist for the average scores on sub-categories for groups defined by each demographic variable

Demographic Variable	P-values for Sub-categories				
	1 Leadership in my Dept.	2 Leadership Practices in HIM	3 Recruitment & Retention	4 Succession Planning	5 Policies & Procedures
Health Region	.230	.111	.008*	.179	.228
Gender	.834	.243	.384	.872	.565
Age Range	.914	.194	.972	.384	.012*
Size of Staff Complement	.001*	.006*	.328	.023*	.086
Tenure of Employment	.303	.263	.859	.067	.003*
Type of Institution	<.0001*	.001*	.020*	.241	.079

Based on the P-values provided in Table 5.7, it can be concluded at the 5% level of significance that differences in the average ranks for the scores on sub-categories 1 and 2 exist after classifying by size of HIM staff complement and type of institution.

Table 5.8  
*P-values for significant pairwise comparisons*

Sub-category	Paired groups	Adjusted P-value (Bonferroni Correction)
1 Leadership in my dept.	<b>Size of HIM staff complement</b>	
	11 – 15                      26 – 30	.019
	Over 30	.037
	<b>Type of Health Institution</b>	
	Specialist                      Type 4 H/C	.032
	Type A                      Type C Type 4 H/C Type 5 H/C	.026 .001 .044
2 Leadership practices in HIM	<b>Size of HIM staff complement</b>	
	11 – 15                      16 – 20	.013
	Over 30	.038
	<b>Type of Health Institution</b>	
	Type A                      Type B Type C Type 4 H/C Type 5 H/C	.046 .001 .004 .022
3 Recruitment & Retention	<b>Health Region</b>	
	SERHA                      NERHA	.015
	<b>Type of Health Institution</b>	No significance based on the adjusted p- values
4 Succession Planning	<b>Size of HIM staff complement</b>	
	6 – 10                      16 – 20	.042
5 Policies & Procedures	<b>Age Range</b>	
	Below 25 years                      36 – 45 years	.014
	Over 46 years	.033
	<b>Tenure in HIM Employment</b>	
	1 – 5 years                      Over 20 years	.010

In addition, differences exist for sub-category 3 after classifying by health region and type of institution; for sub-category 4, after classifying by size of HIM staff complement; and for sub-category 5, after classifying by age range and tenure in HIM employment. The specific

differences can be determined by analysing the pairwise comparisons. The summary of these comparisons are provided in Table 5.8.

## **5.5 Analyses of research questions**

**Research Question 1.** What leadership practices currently exist in Jamaican organisations involved in the leadership and management of HIM? This section of the results begins with the leadership styles practiced among HIM practitioners, then into recruitment, retention and succession planning for HIM practitioners, through to their perceptions of what it is like trying to identify people to fill HIM leadership positions in Jamaica.

*Sub Category 1: Leadership in my department.* The first set of items in this chapter dealt with the types of leadership that were practiced in the departments where participants worked. Over 68% of participants agreed to some extent (54% agree; 14% strongly agree) that leadership in their department demonstrated commitment to professional development. For the item, leadership in my institution creates opportunities for personal and professional development, the affirmative responses were 55% (45% agree; 10 % strongly agree); while the undecided responses were just over 20%. Just over 51% of participants were in agreement that leadership in their department inspired and motivated staff; while over 30% were in disagreement. See Figure 5.3.

While a cumulative 50% participants agreed that leadership in their department allowed them to participate in decision-making processes, in total over 31% disagreed. Participating in leadership activities is an important activity in leadership grooming and capacity building. As participants shared, less than 50% of the staff were afforded these opportunities by their leaders. Just under 40% of participants were in some level of agreement (30% agree; 9% strongly agree)

that leadership in their departments provided opportunities for them to participate in leadership activities; 36% were in some level of disagreement, while 23% were undecided. When asked whether leadership in participants' departments were in the habit of seeking to build leadership competencies in the staff, a total of 40% agreed and 31% disagreed, while 19% returned an undecided response.

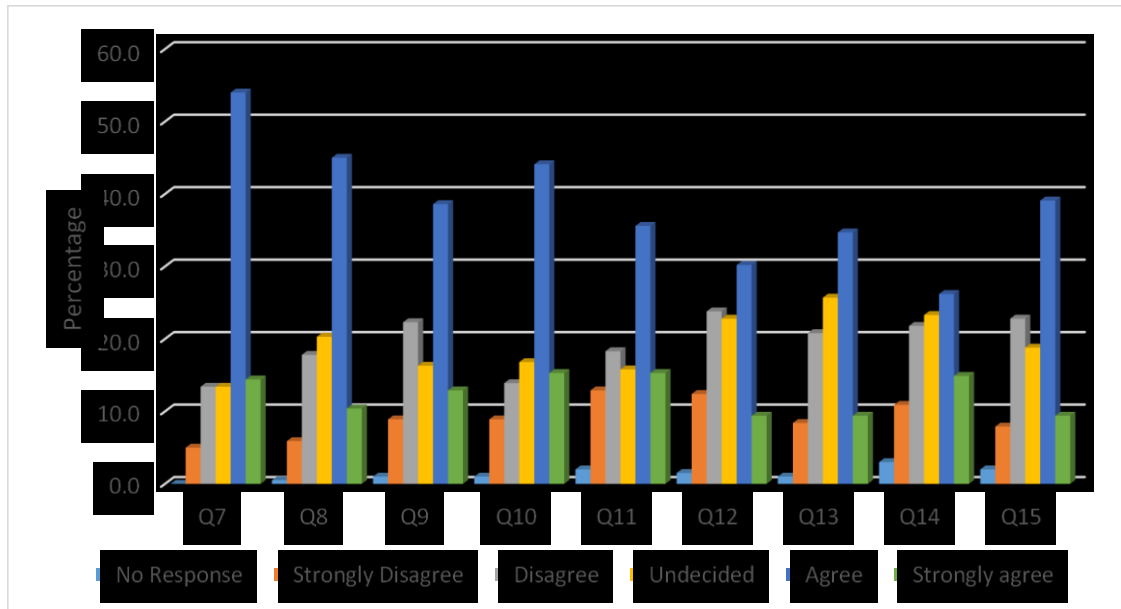


Figure 5.3 Percentage distribution of responses for items in Sub-category 1.

The next item was intended to determine whether leaders in these departments were encouraging or challenging those staff members who were never involved in leadership roles or activities to take on leadership roles. As the responses indicated, 44% expressed agreement, just under 30% expressed disagreement, while 26% were undecided. The last item in this sub-category-category addressed a transactional type of leadership. Responses illustrated that 41% of participants were in some level of agreement that leadership in their departments were more task-oriented than people-oriented, 32% were in some level of disagreement, while 23% were undecided.

In this sub-category, the undecided responses ranged from 13% to 26% indicating that for some items, over 25% of the participants expressed some amount of uncertainty regarding how leadership was practiced in their departments. For each type described, the affirmative responses ranged from 40% to 68% and the levels of disagreement ranged from 18% to 36%. These results indicated that there was no one style of leadership that was practiced in these institutions where the participants worked and among HIM professionals. Neither was there any one dominant style of leadership that was practiced among HIM practitioners. In some instances the prevailing leadership practices were not easily described and participants returned an 'undecided' response.

As demonstrated in Figure 5.3, in this sub-category, for the first five items (Q7-Q11), between 52% and 69% of participants responded in the affirmative about leadership and professional development in their department. In the same vein, for the next three items (Q12-Q14) which expanded on leadership and professional development, the affirmative responses fell between 40 and 49%; while the levels of disagreement for these items was relatively high and ranged from 33% - 44%. The percentage responses for undecided ranged from a low of 13% to a high of 26%. Responses to the last item in this sub-category (Q15) showed almost 50 % agreed that leadership in their department was more task-oriented than people-oriented. These responses indicated that a transactional type of leadership was being practiced in those institutions; while the previous items indicated other types of leadership.

In this study, interviewees reported that several leadership styles were practiced among HIM practitioners in Jamaica. These include participatory, autocratic, and authoritative; but the one most dominant was democratic, and in some instances, a blend with elements of other leadership styles. One interviewee described the current leadership practices among HIM practitioners as:

*They don't communicate well but they are trying to get the work done. Not excellent but satisfactory* (Practice Leader 1, female)

Another interviewee expressed that the current leadership practices could not be described in relation to any particular leadership style nor in any one particular way but the best way to describe the current leadership practices among HIM practitioners as she experienced it was:

*Leading by example and just being a good mentor to your team* (Practice Leader 3, female)

However, there were differing views from the field in that:

*Leadership is based on goal-oriented tasks. Less emphasis is placed on the staff... so it is more like getting the job done than looking out for the staff* (Practice Leader 2, male)

The views expressed by practice leaders were somewhat similar to those expressed by the academic leaders. One academic leader described leadership among HIM professionals as:

*Democratic with some autocratic involved in some aspects; along with dictatorship involved* (Academic Leader 4, male)

Another academic leader expressed that in the current HIM practice:

*Leadership is weak. They do what they feel like. It's laissez faire* (Academic Leader 2, female)

The views of policy leaders were similar to the above responses. Concerning the current leadership practices in HIM, it was described as mainly democratic but:

*Some of it may be laid-back, laissez-faire. I would say democratic and laissez-faire. Maybe it's 50:50.* (Policy leader 2, male)

To summarise the responses in this sub-category, a hybrid of leadership types were being practiced in the institutions where participants worked but it appears that leadership was fragmented.

*Sub-category 2: Leadership Practices affecting HIM.* The next set of the scale items, were in Sub-category 2, and the items here were related to leadership practices affecting HIM

practitioners during their daily work interactions. The first item in this sub-category (Q16) addressed participants' view of the level of confidence that they had in their supervisors. For this item, just under 50% returned a positive response, 28% gave a negative response, and 20% were undecided. About 47% of participants agreed that the HIM staff was willing to take on leadership roles and another 8% strongly agreed. On the other hand, in total, about 24% disagreed and 20% were undecided. The next item (Q17) was about whether HIM supervisors displayed confidence in leading others. To this item, 60% were in some level of agreement, 20% expressed some level of disagreement, and 20% were undecided.

Concerning whether leadership capacity was evident in the existing HIM staff, 61% of participants agreed to some extent, 17% disagreed, and 24% were undecided. Over 60% of participants agreed that HIM practices were in line with established procedures and guidelines; 15% disagreed, and 24% were undecided. There was a marked decline in the affirmative responses (31%) regarding the next item (Q21) that addressed identifying people to fill HIM leadership positions. That is, 25% agreed, while 5 % strongly agreed. The negative responses totalled 34%; while the undecided responses rose exponentially to 35%. This high percentage in undecided responses was difficult to unravel but it provided an indication that there was a challenge in this area.

As highlighted in this second sub-category which addressed leadership practices in HIM, affirmative responses for the first five items (Q16 – Q20) ranged from 50% - 61%, undecided ranged between 20% - 24%, while the percentage that disagreed ranged from 14% - 28%. The fifth item in this sub-category showed that over 60% of participants were in agreement that the HIM practices were in line with established procedures and guidelines.

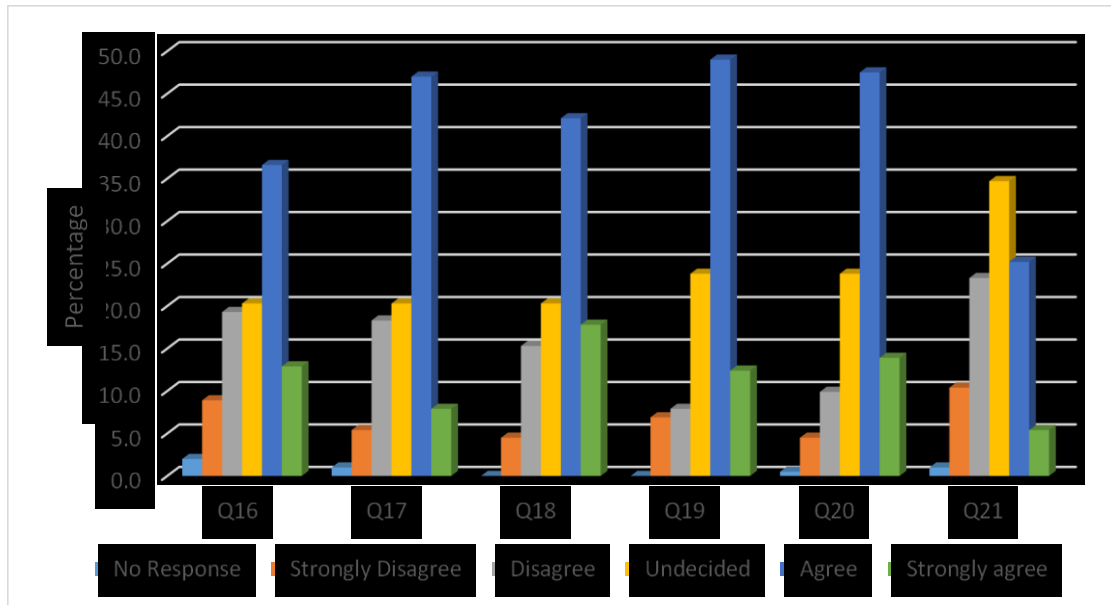


Figure 5.4 Percentage distribution of responses for items in Sub-category 2.

Responses to the sixth item (Q21) in this sub-category were almost evenly distributed with 31% in agreement, 34% in disagreement, and 35% undecided about whether it was easy to identify people to fill HIM leadership roles.

Overall, in this sub-category, the undecided responses were high, ranging between 20% and 35%. Once again, these results were unexpected as the items in this sub-category were specific to what was happening in the practice. This appears to be an area of concern for HIM leadership because although, slightly, the undecided responses were still the highest in this category.

*Sub-category 3: Recruitment and Retention.* The next set of items examined recruitment and retention among HIM practitioners in Jamaica. The first item in this sub-category (Q22) looked at participants' view of their department's adherence to established methods for recruiting HIM staff. Responses were in relation to the general methods used for recruitment, as there were no established measures that were specific to recruiting HIM practitioners. Their responses illustrated, approximately 50% were in agreement, 19% in disagreement, and 28% undecided.



The next item addressed timeliness with recruitment of HIM staff. Just under 24% were in some level of agreement, 54% were in some level of disagreement, and 22% could not give a definitive response. Through these responses, participants indicated an obvious tardiness with recruitment in their department. This is another area of concern for HIM leadership and management.

Participants were asked whether they found their job fulfilling and felt valued being HIM practitioners. Responses to this item were 57% in some level of agreement, just over 22% disagreement, and 20% undecided. These undecided responses were unexpectedly high as this item spoke to how each individual felt about their own work. Another investigation would be required to provide meaning to these responses. In the meantime, the interview results provided some clarity. As illustrated in Figure 5.5, concerning whether employee retention helped the development of the HIM department, 51% agreed, just over 14% disagreed, and 33% did not provide a definitive response.

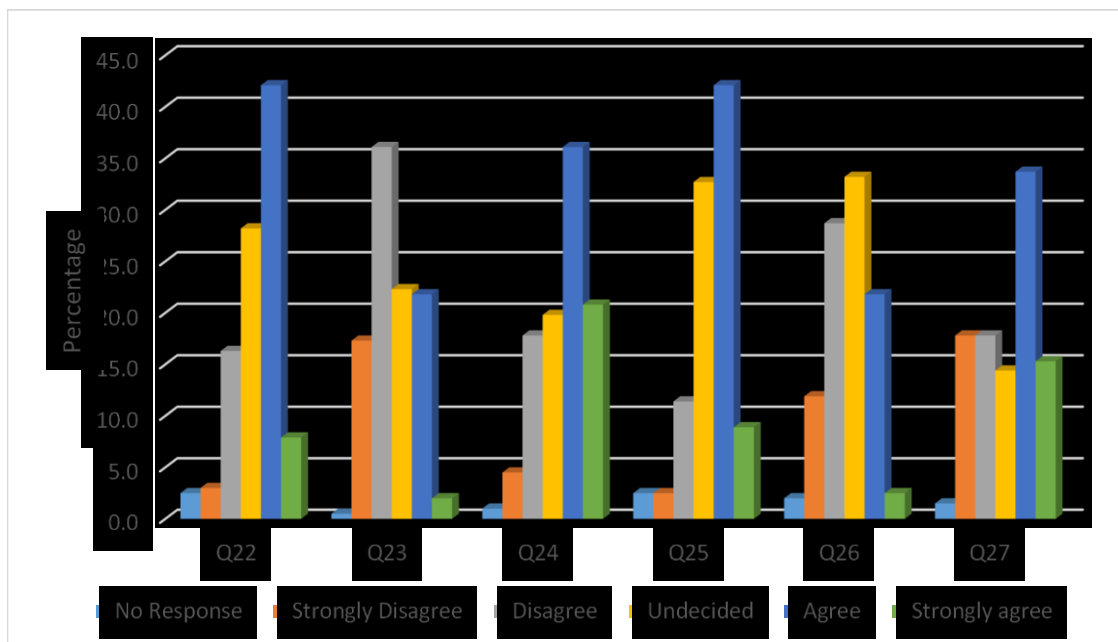


Figure 5.5 Percentage distribution of responses for items in Sub-category 3.

The next item looked at programmes or measures to retain HIM practitioners in Jamaica. As the results indicated, less than 25% agreed, just over 40% disagreed, and 33% were undecided. In relation to excellence in communication within their department, 53% were in the affirmative, over 35 % in the negative (equally divided between disagree and strongly disagree), and 14% were undecided. As the results indicated, less than 25% agreed, just over 40% disagreed, and 33% were undecided. In relation to excellence in communication within their department, 53% were in the affirmative, over 35 % in the negative (equally divided between disagree and strongly disagree), and 14% were undecided. Responses to the items in this sub-category varied. Affirmative responses to four items (Q22, 24, 25 & 27) in this category were somehow consistent and ranged between 50% and 57%. However, for the other items (Q23 & Q26), the affirmative responses were 24%, rounded off for both.

The percentage of undecided responses for all items in this sub-category ranged from a low of 14% to a high of 33%. As shown in Figure 5.5, the percentage of participants in disagreement with four items ranged from 14% to a high of 36%. However, for the other two items, the percentage of participants that disagreed were 53% and 41% respectively.

Interviewees offered varied responses in relation to how HIM practitioners were recruited in Jamaica. These responses in some way underscored that recruitment was managed by the human resources department and at times done through informal advertisements, job applications (not necessarily specific to HIM but maybe for any vacant position in the health facility), interviews, and on-the-job training. Practice leaders explained that when it comes to recruitment of HIM practitioners:

*... It's friends telling friends that there is vacancy.* (Practice Leader 2, male)

But this ad hoc means of inviting interests meant that some HIM practitioners were being recruited, as Miller (2013a) described in the literature, through “religious affiliations” and “social connections” - premising social capital over human capital.

*There are no formal advertisements, except for internal. People will ask from their church or their community..., people may come into the institution and ask and then they are encouraged to apply. Otherwise through church or social groups. Or people may just apply randomly. (Practice Leader 5, female)*

According to one interviewee, most of the activities in the recruitment process were done by the human resources department and it was only on some occasions that HIM leaders were involved in the process.

*Through the HR system by the HR department. Persons make applications to the facility. HR will make their selection, sometimes they do short-listing and then they will involve the [HIM] supervisors to be a part of the interview (Practice Leader 6, female)*

However, there was a different view.

*For the most part, we advertise. But then again you have others who come in because of political affiliation. Depending on the position, it is advertised in the print media, shortlisted, interviews are done. Based on results of the interviews, a selection is made. Very rare they do interdepartmental (within the health region) advertisements before its gets to the general and if the position is not filled, then they advertise in print media. (Practice Leader 3, female)*

Similar, but more formal responses were offered:

*From my interactions, there is a formal system whereby the advertisement is done and based on qualifications, people apply. There is an informal system where you know someone fresh out of high school ... and looking for a job, and can connect with someone in administration, they can talk with them and the admin people will get them in. There is also a semi-formal system where they come in with ... other related qualifications or experiences in related fields so based on meeting basic criteria they come in and upgrade. (Academic Leader 1, female)*

Also,

*... Sometimes they are already in the field and they are promoted (Academic Leader 3, male)*

While in agreement with the majority of the practice leaders, one interviewee in the academy expanded that:

*Currently ... communication is made to the university ... to ask if there are any graduates or prospective graduands that could fill HIM positions .... I don't see adverts in the gleaner or hear of there being any formal employment adverts. ....I know there are interviews but I have never attended one. (Academic Leader 4, male)*

According to the policy leaders, recruitment of HIM practitioners was done:

*From within the Ministry of Health and the Regional Health Authorities, through a competitive process. (Policy leader 2, male)*

All interviewees shared that recruitment was managed by the human resources department. In terms of who takes part in the process and the roles that they played, responses indicated that different stakeholders were at times involved in the recruitment process but this was not standardised. Also, the interview process was done by a panel that included representatives from the HR department, the facility's administration, and the senior HIM staff within the facility. However, there were variations in terms of the other representatives who were at times invited to join the interview panel and exactly how the process was undertaken. Interviewees explained that:

*HIM Administrator would communicate staffing needs ... to HR. ... In the interviews, HIM Administrator – [focus on] the roles in HIM, give scenarios and ask [candidates] how they would deal with the scenarios presented.  
HR – tells candidates the benefits such as vacation leave, sick leave, health benefits and so forth.  
HIM Administrator will have the edge in choosing the desired candidate. (Practice Leader 1, female)*

But this was not common practice throughout HIM organisations as according to another interviewee:

*The HIM Administrator – is responsible for choosing the persons at times. Usually three to four members are on the panel, mostly from HR but, as the senior HIM, I am always on the panel.... My role is to select [the candidate] for employment.*

*HR's role is to help with that process but I am usually given priority in terms of who to select. (Practice Leader 2, male)*

Still, another interviewee expressed that the recruitment process for HIM practitioners involves:

*Mainly senior managers – HIM administrator, HR and hospital managers – depending on the position. HIM administrators – do the technical aspect ... HR's participation is to present situations and ask [candidates] how they would deal with such situations. ... They also look at soft skills and customer service.*

*Other senior managers – focus on soft skills and customer service, and past job/work experiences.*

*Members of the facility board deal with personality, soft skills, customer service, and job or work experience. (Practice Leader 3, female)*

While most aspects of the process were similar, the method of selecting candidates was at times different in that:

*HR department – Personnel Officer ensure that the persons who they are employing are satisfactory for the department.*

*Senior HIM staff – ... ensure that the persons that are going to be recruited are competent to manage the tasks that will be [assigned].*

*If recruiting for [senior] HIM positions, the CEO, or Parish Manager or MoH, depending on the facility, would be on the panel. Basically, they try to have an understanding of what this person is all about and if we are choosing the right person for the position.... If [the panel] is not comfortable with the candidates, they may re-advertise until they [identify] that suitable person.*

*The final decision is made based on recommendations and scores ... It is usually a unified decision ... [regarding] the most suitable person for the position (Practice Leader 6, female)*

Other practitioners reported a similar process but shared that at times, even with good intent, there was some meddling, described by Miller (2013a) as jockeying or “interference” in the recruitment process (p. 178).

*HR does the recruiting, send out ads, etc. The parish manager [is involved] somewhat. The senior HIM – would have [an input]. Sometimes, the parish manager wants to push someone down your throat. If you are not a strong person, they will do that. (Practice Leader 4, female)*

In other instances, the process is still prejudiced as:

*The senior HIM – will go through the applications with HR and do short listing ... so you know if there is someone from your church and so on, you know you are going to pull out that person.*

*HR – Notifies candidates after they are short-listed and arrange interviews. In communication with senior HIM, HR schedule dates for the interviews, and select the panelists. The hospital administrator ... poses questions ... and then at the end of the day there is a discussion so that everybody can select the person they all can agree upon. If the senior HIM is adamant that they don't want the candidate, then it is not ... but I have seen where they have sent persons to the HIM department that the senior HIM did not sit on the interview panel for ... (Practice Leader 5, female)*

Academic leaders reportedly did not directly participate in the recruitment process and so did not have first-hand experience but from their interactions with HIM personnel, they understood that the recruitment process is done through:

*[A] panel whose role is ensuring that the candidates meet the criteria, and that they are competent. The team assesses their soft skills and whatever other competence. (Academic Leader 1, female)*

*.... At the seeking stage (as there is no formal advertisement) of the recruitment, the [HIM] administrator tries to identify persons who could be prospective employees ... He or she is like a champion for this whole activity ... the champion rigorously [makes enquiries] if there are any trained and when that is not forthcoming then untrained persons to apply for jobs.*

*At the interview stage ... I am not sure who sits on the panel... But, between HR and HIM, they develop the contract. (Academic Leader 4, male)*

At the ministry level, recruitment is done through the human resources division and the directors of the related unit participate in the process. These directors:

*... will have a role to play in the short listing and interview processes. (Policy leader 1, male)*

When recruiting for the senior HIM practitioners or for HIM leadership positions, the directors would work with the human resources department in that these directors would make the request to the HR division and HR would in turn advertise internally (within the health ministry). After the request is made,

*HR would put the fielders out to the different places or persons would be invited to apply. HR reaches out to the regional health authorities. (Policy leader 2, male)*

In addition, interviews are conducted through a panel.

*HR would focus on soft skills, and there would be an external member such as someone from the Office of the Services Commission – ... this person would be there to ensure that the process is carried out according to government regulations. The HIM supervisor is an expert in the area who would deal with the technical aspect. The external may also be an expert in the area. They look at knowledge and attitude that the candidate is taking to the job. (Policy leader 3, female)*

To summarise this aspect on recruitment, the results indicated that recruitment was not usually timely. Different stakeholders usually participate in the recruitment process and in some instances, the roles were balanced. However, at times there was interference in the recruitment process (Miller, 2013a) resulting in biased selection of candidates.

*Retention of HIM practitioners in Jamaica.* Interviewees expressed that in Jamaica, retention of HIM practitioners continues to be a challenge. Some were unaware of any particular measures to retain staff, or that there were any special measures to retain HIM practitioners in Jamaica. Others stated that no retention measures were in place and:

*In some facilities, the turnover rate was so high. By the time they come in, you hear that they are gone. (Practice Leader 3, female)*

*We who stay only stay because of the love [for the profession]. (Practice Leader 4, female)*

*... More could be done to retain those person in terms of posts. (Practice Leader 2, male)*

However, there were indirect non-permanent means of retention such as study leave and sponsorship, and bonding them. Otherwise,

*I don't think ... there is actively any measure [to retain] but there is some encouragement of some sort .... I don't see enough being done to encourage, whether through a professional association or from the ministry level ... for HIT/HIM to remain in service in Jamaica ... (Academic Leader 4, male)*

Further,

*I would not say any special measures are there because we have not had that discussion. We sponsor them and we bond them for a maximum of five years (Policy leader 3, female).*

*Identifying people to fill HIM leadership positions.* Interviewees unanimously expressed that it was challenging trying to identify people to fill HIM leadership positions in the Jamaican setting. Describing their experiences in pursuit of such talents, they shared that it was very difficult:

*... We face the situation where more than 50% of the staff are not trained. Even if you identify persons who are good leaders, you can't put them in the position because they are not trained. And even if they are trained ... they do not have the leadership skills. (Practice Leader 3, female)*

In addition,

*Persons are in the system who have ability to assume leadership roles but they are not given enough exposure ... and the opportunity to assume leadership roles .... Whenever somebody leaves, to fill that gap, it is not easy because most of those who are on training are affiliated to other facilities or other regions .... I think persons are available ... but when you put someone in a leadership role that gap is left. ... It poses a challenge within the system. (Practice Leader 2, male)*

Furthermore,

*You have persons who are trained but do not want to take on the responsibilities ... [they fear] they can't manage. They doubt their competence in terms of managing ... although they have the [academic] qualifications, they still lack using those skills for which they were taught. (Practice Leader 6, female)*

This was further complicated by the inadequate number of trained personnel.

*It's hard because of the small number of trained people ... and sometimes you are faced with a situation where the available people are not up to standard but you just have to choose someone ... (Practice Leader 5, female)*



Identifying people to assume HIM leadership positions required some assignment of leadership roles and subsequent assessment but this could be done only with supervisors and their reports.

In such instances,

*... We assign them areas and see how best they perform so based on the [performance appraisal], we see if they qualify for any leadership role / promotion ...* (Practice Leader 1, female)

But, there were other contributing issues. Attrition was reportedly an underlying cause because:

*Most persons who come, they branch off into other areas .... They don't stay in HIM...* (Practice Leader 4, female)...

But, another response was at the opposite end of the spectrum.

*It is not difficult because there are so many people who are potentially qualified and want to self-actualise so they would see it as an opportunity for upward mobility.* (Academic Leader 1, female)

However, based on what the other academic leaders shared, they were in sync with the practice leaders.

*It's like you are moving and you get the strongest weak person to put in the position [to lead]. I use that word based on what I am seeing.* (Academic Leader 2, female)

Moreover, the challenges were underpinned by different causes that were reportedly linked to the level at which the pool of HIM practitioners were trained and their unprofessional conduct.

*That's like pulling teeth when you are trained only as an electrician. It is very difficult and the difficulty is two-fold. Number one, we just don't have enough persons with the qualification for HIM ... because those persons should have, at minimum, a bachelor's ... undergirded by a lower certification in HIM ... there is the attitudinal part of it too ... and the profession ... suffers from unprofessional behavior/conduct.* (Academic Leader 4, male)

Another interviewee agreed that there was indeed a difficulty but was optimistic that in a few years the stated challenges would cease to exist.

*Currently, it is kind of difficult to get persons with good experience that are trained. I think in another few years, we'd have enough persons.* (Academic Leader 3, male)

Identifying leadership talents on the field was challenged by a number of other limitations such as inadequate number of trained personnel to assume leadership roles and inability to fill gaps that would be created when someone was promoted:

*Even within the pool from which you are expected to draw, not a lot of persons had studied to [that level] .... The number of persons who are qualified at that level is limited, and if you go lower, you may also face a challenge in that ... a significant number of [HIMs] in the field have not been exposed to formal training ... or have the necessary certification. [There is] not enough trained persons to fill other slots ... and even though the process is supposed to be one based on merit, it is a competitive process. (Policy leader 2, male)*

For most Jamaicans, an organisation having a succession plan means that there is a specific individual that is groomed for a particular position; and in rare cases two people may be groomed. When that is done, positions are not advertised, rather those groomed just transition into the positions. But is that purposeful succession planning? And what if the one or two who are groomed decide to separate from the organisation? It was explained that HIM leadership:

*Positions are not filled based on a succession plan. They are advertised and people apply. Positions are filled competitively. (Policy leader 3, female)*

However, the question is, could this arrangement of advertising and filling positions competitively, not be part of a succession plan? After all, a succession plan is not a public document; nor is succession planning a public process.

*Could the academic institution identify leadership talents on the field?* Interviewees shared their perceptions of the HIM training institution identifying people from the field to assume HIM leadership roles. To this question, different responses were offered with majority of the interviewees expressing that either the HIM training institution would experience some challenges trying to identify such talents, or they just would not be able to identify HIM practitioners from the field to assume leadership roles.

*I would not say it's easy because the people in the academic institution do not see the people on the field in action on the job ... You can but it would be based on how that person was during the period of training. (Practice Leader 5, female)*

While another interviewee would not describe the process as easy, there was some level of agreement.

*It depends on what the leadership role entails, if it's a teaching capacity or a management capacity. Management, I would agree. Teaching, I think they would need more classroom time to venture into teaching. Probably a ... course to propel them into that direction (Practice Leader 2, male)*

Another determinant would be the requirements of the academic institution.

*... It depends on the academic requirements of [the institution]... (Practice Leader 6, female)*

Notwithstanding these views, others strongly felt that the training institution just could not identify people from the field to assume leadership roles.

*I am not familiar with the full curriculum now but I don't think enough time is there to really identify because seeing the students there is a totally different thing from when they go out to the field to work. I don't think the school is able to identify them at all. (Practice Leader 3, female)*

Moreover,

*... The issue is us and how we behave. Sometimes, those of us that even look professional, when we open our mouth, it's a different thing. Lack professionalism (Practice Leader 4, female)*

One respondent offered a differing view and affirmed that the training institution could easily identify people from the field to assume leadership roles but such identification would be based on the observations made while these HIM practitioners were in training at that specific institution.

*I believe so because [the institution], after they have completed training, they send people back into the field to work... Based on their performance, if they possessed*

*leadership skills, if they participated in class, and other ... activities on campus...*  
(Practice Leader 1, female)

One academic leader felt that the training institution could easily identify people from the field to assume leadership roles based on observations made of these HIM practitioners while they were engaged in their academic pursuits:

*We train them, we know them so it's easy. We look at their demeanour while being trained, how they respond to the training, we see those who are natural leaders. So, it is not difficult to identify them.* (Academic Leader 1, female)

However, other academic leaders thought that while it may be easy to identify HIM practitioners with specific leadership qualities that could be groomed, the leadership capacity in HIM practitioners was not readily available. Nor was it easily identified. Hence, there would be some challenge trying to identify people from the field to assume HIM leadership roles in the academy.

*Not unless [the institution] has close relationships with the HIM departments. ... If they trained those persons, maybe [the institution] can identify specific leadership qualities in them ....* (Academic Leader 2, female)

Considering institutional standards and matriculation requirements along with other factors,

*... Some traits could be identified. Some ... identification of potential. The academic institution has its own sets of standards and its own matriculation requirements ... and even to assume leadership positions within the institution, persons with that sort of capacity merely exist... if it's in relation to identifying people who could be groomed, that is another matter that could be done with less difficulty... but again, it's not easy*  
(Academic Leader 4, male)

However, there was optimism that the position of the training institution could change with more HIM practitioners accessing higher levels of academic training.

*... Most persons that have done the HIM course don't advance to a master's level. To get persons from the field, currently it's not easy but that can change over time* (Academic Leader 3, male)

Policy leaders shared opposing views.

*... I don't recall us calling upon them but yes, they should be able to having had a broader view. ... As long as [practitioners] were trained at that institution (Policy leader 3, female).*

Another expressed similar sentiments with some reserve:

*It's kind of difficult to respond. ... To an extent maybe they [HIM practitioners and their leadership competencies] can much better be observed [by the academic institution] than the Ministry of Health. I guess I could agree that the training institution may be better placed to identify such skills, if they all pass through [the institution]. The only challenge would be if they didn't access their training there. (Policy leader 2, male)*

However,

*... while the training institution can make a selection based on some perceived qualities it develops, it is the persons working in the field that better understand the realities facing the HIM professionals. Any selection should be a collaborative effort. (Policy leader 1, male)*

Based on the responses provided, it is safe to accept that it is not easy for either the practicing institutions or the academic institution to identify people from the field to assume HIM leadership positions.

***Challenges to recruitment, retention and succession planning. Recruitment challenges.***

Interviewees were next asked about challenges related to recruitment, retention and succession planning among HIM practitioners in Jamaica, and arrangements that existed to address those challenges. Interviewees stated a number of challenges mainly in relation to training and lack of trained personnel, remuneration, working conditions, inadequate numbers of established posts, and the extended time for permanent appointment. They also shared that arrangements were in place to address some of the stated challenges. They explained that practitioners were willing to access formal training but they were deterred by low salaries and this also negatively affected recruitment. Another challenge was the scarcity of trained personnel.

*We are not getting enough trained person into the system. More than 70% of the persons are untrained and with [new data needs and a new system in place] it requires more persons with the requisite skills. (Practice Leader 2, male)*

Furthermore, the issue was complicated by length of time spent doing in-house training.

*We don't get trained persons... We always end up having to give them the basic training which takes a while because it depends on how fast they learn. If we had them trained, all we would have to do when they come is orient ... [but] we have to be training all the time. .... (Practice Leader 3, female)*

Retention was also affected by unstable employment contracts and poor employments benefits; hence the high turnover rate.

*People come in and want something stable that they know they can get benefits. When you have someone on contract ... there's no benefit so they don't want to stay. As they see something greener, they are gone.... (Practice Leader 3, female)*

There were also relational issues and opportunities for upward mobility were lacking.

*The culture of HIM is that people view it as a stepping stone to other professions. ... [No] upward mobility ...Persons will go for formal training but they come back and they are stuck in the same position ... no improvements or changes... Their ideas sometimes are not explored. Depending on the relationship with their supervisor, they may feel discouraged so they leave. (Practice Leader 5, female)*

Moreover, they felt that the human resources department was prejudiced in their actions.

*We have persons who are equipped to do the job ... but they are somehow side-lined by HR. And at times, the selection is done only by HR, for the top positions. (Practice Leader 2, male)*

But, there was a more serious concern.

*The trained people continue to leave. If people are not staying then who will be the successors? It is going to be limited .... (Practice Leader 5, female)*

*Arrangements to address challenges identified.* Interviewees reported several concerns with no particular arrangements in place to address the issues mentioned. However, as an encouragement, at times approval was granted for the trained staff to act in leadership and

management positions although they were not appointed. Notwithstanding the stated challenges, and seemingly unaware of the benefits of retention, one interviewee said the recruitment process was at times delayed but she had no problem with retention because:

*The staff don't leave and I wish they would sometimes leave for upward mobility and we can get others to come.  
The only arrangements in place are writing letters, talking with HR, and doubling up staff until the [recruitment] process is completed* (Practice Leader 1, female)

There were other issues such as poor vision of HIM leaders, and the competitive salary offered by international institutions employing HIM practitioners.

*... Overseas they offer better pay and we cannot match that so we could easily loose them. So there is the inability to remunerate at the level that the developed countries can. Limited opportunities for HIM practitioners or the lack of vision on the part of senior leaders – whether at the institutional, regional or ministry level – to create these opportunities* (Academic Leader 1, female).

In addition, there were other challenges to recruitment such as the lack of posts to permanently appoint employees, inadequate opportunities for professional development, and ignorance regarding the profession.

*It appears that the number of positions and posts that reside in the public sector are limited. Beyond that, there are some drawbacks as it relates to lack of professional development of the staff and a lack of awareness of the importance and the role that HIM plays in health care and as a result of that, there is not much attraction to the profession...* (Academic Leader 4, male)

[Ineffective] leadership was another issue:

*Leadership is not strong enough. If you have a strong leaders ..., then the department is built because the [leaders] will [insist that they are] not going to take [untrained staff] in the department* (Academic Leader 2, female).

*Retention challenges.* As regards retention, challenges among HIM practitioners in Jamaica were no less. While some of the stated challenges were similar to the challenges with recruitment, retention was continuously affected because of:

*The lengthy time it takes to be appointed (Policy leader 3, female).*

*Most times they start in HIT and then move on because the salary is not the best so ... people try to move on to a more lucrative field (Academic Leader 3, male).*

And there were:

*Upward mobility issues. HIM practitioners usually cascade into other areas (Policy leader 2, male).*

Furthermore, there were no known arrangement in place to retain:

*[E]xcept forcing people to remain on the job by bonding them after study leave. (Academic Leader 1, female)*

*Succession planning challenges.* Some of the challenges affecting succession planning among HIM practitioners were similar to those already stated as affecting recruitment and retention. Interviewees expressed other challenges such as reluctance on the part of practitioners to access training and:

*Those who sit and are not trained, you can't put them in your succession plan, because you need persons to be leading and managing your department. (Academic Leader 2, female)*

In addition,

*... One problem is to release them for training so they can be equipped (Policy leader 3, female).*

Furthermore,

*The problem with succession planning is that such a plan has not been developed [and there are no] arrangements in place to address these challenges. (Policy leader 2, male)*

Additionally, these challenges were compounded by poor working conditions, a lack of understanding of the work and worth of HIM professionals, and lack of recognition of the value of HIM.



*Working conditions are poor – the very buildings and offices are not attractive and people are not stupid. They are doing their research before they express interest – that could determine their interests (Policy leader 3, female).*

Another issue not to be sidelined was that:

*People discount HIM because they don't understand what the profession is about and its importance. Even some of the very HIM staff themselves, they don't seem to place a value on what they do... (Policy leader 3, female).*

Therefore, it remains a challenge to:

*[E]nsure that the profession is attractive to prospective candidates. Persons need to know about the work of the HIM professionals in the healthcare sector; and see it as adding value to the delivery of healthcare and improved health outcomes. (Policy leader 1, male)*

*Summary for Research Question 1.* A number of challenges were highlighted in relation to recruitment, retention, and succession planning in HIM. However, minimal arrangements were in place to address some of the stated challenges.

## **5.6 Chapter summary**

Multiple leadership styles were being practiced in HIM in Jamaica, but it appears leadership is fragmented. It is difficult trying to identify people to fill HIM leadership positions. There were a number of challenges related to recruitment, retention and succession planning among HIM and these challenges were compounded by poor working conditions, a lack of understanding of the work and worth of HIM professionals, and lack of recognition of the value of HIM. No arrangements were in place to address some of the stated challenges.

The next chapter addresses the other research questions and entails roles played by HIM leaders and other stakeholders in the succession planning and the development of the HIM profession in Jamaica; and the policies and procedures used in HIM.

## Chapter 6 - Results and Data Presentation Part 2

**6.1 Research Question 2 Analysis.** What role and impact do HIM managers have in succession planning (capacity building and professional development) and the development of the HIM profession? How has this impact been measured and assessed by different stakeholders? This section begins with survey participants' views in relation to these two questions, and continues into interviewees' perceptions of the roles played by HIM leaders in relation to succession planning among HIM practitioners and the development of the HIM profession in Jamaica. It also entails their perceptions of how the impact of such roles have been captured, measured and assessed by different stakeholders.

*Sub-category 4: Succession Planning in HIM.* This research question captures the items that addressed succession planning among HIM practitioners. As the issue of formal training has been a worrying one for HIM practitioners, participants were asked whether there was adequate support in place to facilitate them accessing formal training. The data revealed, 34% were in different levels of agreement, 44% were in some level of disagreement to this item, and 21% were undecided. As Figure 6.1 highlights, just below 23% were in different levels of agreement that there was a HIM leadership succession plan in place; 37% were in some level of disagreement, and above 40% were undecided. As this affects the capacity building and professional development of the HIM practitioners, this is another area of concern for HIM leadership and management to give some attention.

Participants were next asked to respond to the statement "My department identifies potential talents in HIM practitioners and develops staff to fill senior positions". As seen in Figure 6.1, 30% of the responses were in the affirmative, over 42 % responded in the negative, and 27% were undecided in their responses.

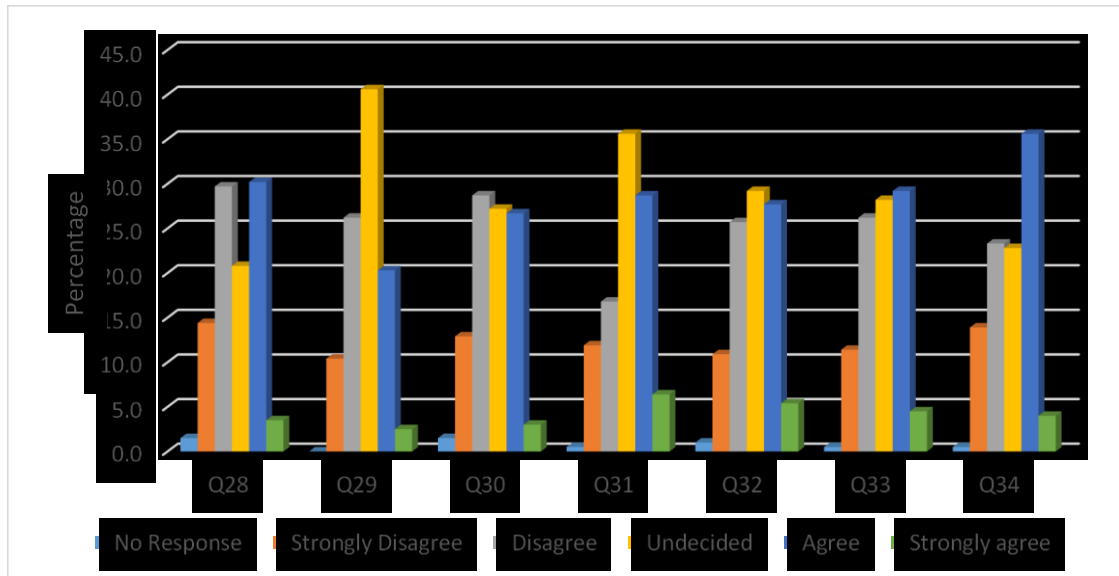


Figure 6.1 Percentage distribution of responses for items in Sub-category 4.

This raises another flag because if potentials are not being identified, how can strategies be put in place to develop same? And what will this mean for the future of HIM leadership? Just over 35% of participants were in agreement that the next head of their department was likely to be identified from within; while under 29% were in disagreement, approximately 36% returned an undecided response. The next item was about whether succession planning was practiced by grooming and promoting leaders from within. To this item, 33% were in some level of agreement, 37% expressed some level of disagreement, and 29% were undecided.

In organisations, succession planning, is done to ensure that when staff move on to other positions or separate from the institution, the position can be easily filled. About 34% of participants were in some level of agreement, and 38% were in some level of disagreement that appropriate measures were in place to ensure that when senior HIM staff leave, the positions can be easily filled; 28% were undecided. This is another issue to be addressed by HIM leadership. While cumulatively 40% of participants agreed that as part of succession planning, their

department heads were involved in mentoring and coaching the staff, in total, over 37% disagreed, and 23% were undecided.

The responses to the items in this section, were contrary to the responses given for items in sub-category 1. A follow-up investigation would help to provide clarification.

The emphasis in sub-category 4 was succession planning among HIM professionals. Affirmative responses to the items in this category ranged between 23% and 40%; the percentage undecided responses for all items in this sub-category ranged from 21% to 41%, and the percentage of participants in disagreement with these items ranged from 29% to a high of 44%.

Interviewees were asked whether there was an established HIM succession plan in place. One practice leader offered a negative response with no expansion or clarification. Other HIM practice leaders offered varied responses indicating that specific staff members were identified and groomed to assume leadership positions, particularly before retirement, as a contingency measure, or in the absence of the head of the department. One interviewee reportedly had a plan in place and it entailed the different levels of personnel - organisational, parish and regional. She expanded:

*Anything can happen so we have to put things in place to identify those persons and try as best as possible to build a certain working relationship with these personnel to guide them in certain areas....* (Practice Leader 3, female)

Another admittedly had a succession place that entailed staff who were close to retirement.

*[These senior staff] would observe people who are there for a very long time and their track record over the years, and other staff members who have a good amount of experience if they are responsible enough to assume leadership roles* (Practice Leader 2, male).

For professional development, some practice leaders were inviting motivational speakers and other stakeholders to deliver presentations in their monthly staff meetings and workshops.

*We invite guests to do talks on how we can propel ourselves ... in terms of training, schooling, upgrading our skills. ... We attend workshops - maybe once per year and it is not every year. (Practice Leader 2, male)*

Another shared:

*... I make sure the person knows everything that I do, make sure he's trained, and make sure he gets the right types of training. So, if and when the position comes ... or if there is a day when I am not here, no one should suffer. We have capacity building training like one week, three week. We attend workshops ... (Practice Leader 4, female)*

The other response focused on filling gaps that would be created by people nearing retirement and those who were migrating. The procedure explained was subjective.

*To some extent ... we have persons who are going on retirement, we are now in the process of looking at persons who we can replace them with. Persons are migrating ..., I will have to now look at who is the next best person to fill that gap. It means that I am moving somebody from one area to another area, maybe in a leadership position. ... I now have to find two persons ... moving one and filling that gap. (Practice Leader 6, female)*

Similarly:

*... I don't know of any [succession plan] except when people are getting close to retirement. That person usually has someone training, preparing them to take over those positions (Academic Leader 3, male)*

Others expressed unawareness that there were established HIM succession plans in place and expanded:

*I don't know that that happens anywhere in the ministry (Academic Leader 2, female)*

*Within the ministry, I am not privy to that information but I would want to think that if there is one, it's not altogether transparent because of an occurrence that took place not so long ago. (Academic Leader 4, male)*

*That's one of the areas that needs to be strengthened. Because it's a small department, it should not be difficult. ... The framework is there but if persons should leave, the gap*

*would be there. So probably that's one of the areas that we need to look at and give some support ...* (Academic Leader 1, female)

Policy leaders confirmed that there was no established HIM succession plan. However, they noted that this is an area where more attention is needed and plans are in the pipeline to develop same.

*It's interesting that you ask because just yesterday the director of HR said there needs to be such a plan.* (Policy leader 2, male)

*... It's something that we are contemplating – doing one for every group. We are looking at our critical areas and HIM is in that group.* (Policy leader 3, female)

From the responses provided, it was clear that there was no established HIM succession plan in place. However, it appeared that there were pockets of succession plans in some instances.

Another area investigated was interviewees' perception of health information managers' role in succession planning and the development of the HIM profession. Mixed responses were offered and these incorporated the roles that health information managers were playing along with, according to interviewees, roles that these practitioners were not playing but should be playing. They articulated that in order to groom leaders in HIM, there is the need to build the capacities of others in the profession:

*We have to make sure that we are good mentors so that the persons coming after us have a good foundation to stand on when we leave. Once you are a good mentor you leave a good legacy behind. Senior people need to play their part and be good leaders. Encourage the junior staff to improve their academic skills. Those who are coming in, find out if they like the profession, introduce the programme to them, and encourage them to [get formal training].* (Practice Leader 3, female)

Also, in order to build the profession, people need to know about it and a number of Jamaicans do not know about HIM. Therefore, to create this level of awareness,

*[We] promote and advertise the profession ....* (Practice Leader 1, female)

Further, as a means of preparing others and propelling the sort of capacity building that is required to appropriately execute HIM functions, leaders in the HIM practice were integral in on-the-job training in that:

*HIM Administrators would organise training for entry level staff. When they come into the profession, we would give them a basic training before they go into the field...*  
(Practice Leader 2, male)

In addition,

*We have to ensure that persons are well-rounded and trained ... but there are other areas to be trained in, supervision, public speaking, et cetera. We encourage [our staff] to take courses on their own too. That we really would not be a part of but ... if they are so motivated they can do it themselves, and we encourage them by giving them the time off to do it. I believe that we need to have continuing education. [For example, we need to] go to different seminars ... read up on the Internet [to increase our knowledge and awareness] ... join the association abroad* (Practice Leader 4, female).

While one could not discount the idea of membership with the International Federation of Health Information Management Association (IFHIMA), it was clear that this interviewee was unaware that the local association, and their representative body, the Jamaica Medical Record Association (JMRA), is an affiliate of the international association, IFHIMA. Therefore, what is required here is information sharing among HIM practitioners and active engagement of HIM practitioners with their local association.

More specifically, in terms of succession planning, there was no established or objective pattern. Rather, the activities geared toward succession planning were done subjectively. Depending on the position to be filled, the process was done by the HIM administrator in the HIM department or the health region.

*We recommend persons who we think could fill gaps. From time to time HR would ask HIM Administrators to recommend people to act for others while they are off.* (Practice Leader 2, male)

They explained that:

*As the head, the HIM administrator is the person working with these future or potential leaders or managers. They are in a position to identify the areas that we need help, to say these are the shortcomings that we have, these are the capacities we need to build... so they play a significant leadership role (Practice Leader 5, female)*

Further, based on interviewees' responses, it was clear that the role played by HIM practice leaders in succession planning was minimal and subjective.

*We have to liaise with the HR department and give recommendations as to who our better candidates are for replacement. Also, we have to do mentoring. Guiding subordinates who are in supervisory positions .... (Practice Leader 6, female).*

With regards to capacity building and development of the profession,

*We look at where our weaknesses are and how to improve on them ... for example, in the area of staff welfare. We also rotate staff in order to develop their skills (Practice Leader 6, female).*

While staff rotation is not common practice in HIM in Jamaica, it is an excellent initiative that has implications for capacity building. Hence it would be more beneficial to the profession for all HIM organisations to embrace staff rotation as an internal professional development initiative (Miller, 2016). Furthermore, along with other initiatives advanced by Miller, such as exchanges and secondment, staff rotation outside of the organisations can be explored for (external) professional development.

Academic leaders did not respond in terms of roles that HIM leaders were playing in succession planning and the development of the HIM profession. Rather, they responded in terms of roles that HIM leaders should be playing. To develop the profession, HIM leaders should:

*Try to nurture their staff and try to build the organisation. The more united and stronger the bond is the greater their voice will be. They need to unite for the same cause and try to move ahead (Academic Leader 3, male)*



They also suggested that for HIM practice leaders to lead and manage appropriately, they need to put systems in place to identify related potentials, and pursue leadership training and development.

*They need to create the framework to facilitate succession planning. They have to ensure that the persons in leadership within the profession understand the importance of succession planning. They also need to make sure that the tools are in place to know and identify the qualities in potential successors... also have the tools in place to have people understudy and mentor as part of the succession planning process (Academic Leader 1, female)*

While interviewees expressed uncertainty concerning initiatives to develop the HIM profession, regarding succession planning, they shared that:

*Once they know the policies, the [HIM leaders], as the heads of department must be able to identify the strength of persons, and then speak with HR regarding the training needs for these persons. For example, to pursue leadership training at [a designated institution]. (Academic Leader 2, male)*

In addition, they expressed that HIM practice leaders should be engaged in assessing:

*... the qualities of employees and probably see who has more management skills ... so they can take on the positions... HIM leaders play a great role in mentoring the young persons and steering them so they understand their job (Academic Leader 3, male).*

In terms of strategies toward development of the profession, interviewees had several suggestions for HIM practice leaders.

They expressed that:

*[HIM leaders] are not doing enough currently... but, they are in a position of influence and as a result they are now in a very good position to ensure that you do whatever is necessary to promote the profession and to ensure that there is visibility. Internally you would have to ensure that you lead and manage appropriately, that you have a plan of gradually training and retraining and retooling your staff. That you develop strategies to ensure that the professional standard is maintained within your institution (Academic Leader 4, male).*

Furthermore, there needs to be some reflection and assessment so HIM leaders need to:

*... ensure that at a particular point some evaluation is made specifically regarding the efforts that you have made to ensure that potential leaders and managers are identified, ensure transparent systems of promotion in middle management level ... and make a concerted effort to ... ensure that there is a succession plan, which ... I have reasons to believe it is probably not [there]* (Academic Leader 4, male).

Like academic leaders, policy leaders' responses were in relation to roles that were played in the past and roles that the HIM leaders should be playing.

*The HIM [Administrator] has a role to play in identifying suitable candidates both in the ministry and in the regions to fill available positions. However, the HR department has a transparent system in place which allows all suitable applicants to apply. The training of HIM professionals is in the work plan for the [HIM] Director and all available opportunities are explored* (Policy leader 1, male).

One interviewee registered unawareness of any role being played but alluded to past roles:

*Maybe it's more an informal type of intervention. I know that in the past persons were identified and encouraged. Identifying scholarships. Those were roles played in the past. I don't know what role they are now playing to move the profession forward.* (Policy leader 2, male)

The other interviewee noted that discussions have not been held regarding the roles played by HIM leaders toward succession planning and the development of the HIM profession but:

*That is communication that should be taking place between the professional body and the Ministry for certain positions but mainly within the institutions at that level* (Policy leader 3, female).

Based on these responses, it appears minimal roles were being played by HIM leaders toward succession planning and the development of the HIM profession such as on-the-job training, advertising and promoting the course of study, and encouraging their reports to seek formal training, and mentoring the staff. However, a lot more needs to be done to create awareness regarding the profession, and discussions need to begin in this regard.

Concerning whether the impact of HIM leaders' role in succession planning and the development of the HIM profession has been captured, measured and assessed by different

stakeholders, the responses varied. Most practice leaders expressed unawareness that any such measurement or assessment had been done. They shared that:

*This has not been measured or assessed ... and sometimes we are overlooked. (Practice Leader 4, female)*

*I don't think anybody has really measured this to see how well or if it is working. I don't think any of our senior managers really sit down and assess. I myself have not done a full analysis. Not directly. (Practice Leader 3, female)*

However, other practice leaders indicated that some assessment had been done based on feedback from their colleagues and other senior managers; and through comparing performance appraisals over the years. These responses were in relation to specific assessment of individuals and not a comprehensive assessment of succession planning in the HIM practice or HIM leaders' role in succession planning and the development of the HIM profession that could help to inform decision-making about leading and managing HIM in Jamaica.

On the part of all the academic leaders, there was uncertainty as to whether there was any assessment of health information managers' roles in succession planning and development of the HIM profession; but they noted that such measurement and assessment should be taking place to inform the practice.

*I am not aware that it is being assessed and measured but ideally that should be done if any organisation wants to maintain a certain level of quality. But, sometimes there are external interferences that can disrupt the process. (Academic Leader 1, female)*

While it was believed that no such measurement or assessment was done, one interviewee noted a possible challenge in doing same.

*The challenge is in measuring the impact of capacity building initiatives. I am not sure any has been done recently. However, through PAHO some specific training needs have been identified and support is given to build on existing capacity. (Policy leader 2, male)*

*Summary for Research Question 2.* Based on the responses provided, it was clear that there was no established HIM succession plan in place but it appeared that in some instances there were pockets of succession planning in place. More should be done to create awareness regarding the profession, and discussions need to begin in that regard. In Jamaica, there has not been a comprehensive assessment or measurement of succession planning in the HIM practice, or the HIM leaders' role in succession planning and the development of the HIM profession. However, subsequent to identifying some training needs among HIM practitioners, one stakeholder organisation has been assisting with capacity building.

*The next section addresses Research question 3.* It entails interviewees' perception of what academic and policy leaders can do to address the challenges identified regarding recruitment, retention and succession planning among HIM practitioners in Jamaica.

**6.2 Research Question 3 Analysis.** This section of the results focuses on interviewees' perceptions of what could be done by academic and policy leaders to address the challenges identified in relation to leadership, recruitment, retention, and succession planning among HIM practitioners in Jamaica. Interviewees proposed a number of strategies that could be explored by academic and policy leaders to address the various challenges identified regarding recruitment, retention and succession planning in HIM in Jamaica. According to the HIM practice leaders, the voices from the field with first-hand experiences, regarding recruitment, policy leaders need to change the requirements for entry into the HIM profession and implement policies to make the associate degree the mandatory entry level requirement. To address the issues of training and recruitment, academic leaders need to promote the HIM courses of study through advertisements and public education/ promotion of these courses because not many people know about these courses of study and what they entail. They shared that academic leaders could address the

issues of succession planning by offering the HIM courses of study in different ways such as offering course delivery off campus or online to make them more accessible for HIM capacity building and professional development.

*Policy leaders need to [put pressure on their seniors] to create posts ... for the people, and give them some form of job security so if they are here till they retire at least they know they will get a pension... They need to put something on the table ... in terms of remuneration for the group. Also, improve the working conditions/ infrastructure as this is a big turn-off for people. Ensure better recognition for the group....* (Practice Leader 3, female)

Policies drive compliance so while the need was expressed for intervention at the policy level, this interviewee also intimated that considering the nonchalance of some HIM practitioners, related measures should be established to ensure compliance at the operational level. In the meantime, these key stakeholders need to address the lengthy recruitment and appointment processes.

*Instead of going through the different boards, policy leaders ... can [appoint] one team or board that deals with employment and appointment ... to shorten the processes.* (Practice Leader 1, female)

Interviewees suggested an automatic transition into leadership and management positions after a specified period.

*Policy leaders could put a system in place where persons who are in the service for a period, like 10 years, and they are qualified, it would be automatic that they are given certain positions, if they have the qualifications and meet the requirements. That would help to address some of the biases.* (Practice Leader 2, male)

But that could be problematic for the main reason that years of employment and academic qualifications by themselves do not qualify anyone for promotion. In addition, that would disenfranchise those who may be seeking employment with similar or better qualifications and or experiences, and may have more to contribute. In relation to retention,

*Policy leaders could offer more incentives where they could get sponsorship ... and put something in place for upward mobility and make it attractive. To address the succession planning issues, policy leaders could ... have people understudy [HIM leaders], then assess, and select the most suitable candidates. Academic leaders could offer some incentives in terms of tuition fee discount, if possible that would help [with capacity building], or [incorporate leadership and supervisory management courses]; while [policy leaders] could probably make it mandatory that HIM personnel do this course OR a short course to cover this content area. (Practice Leader 2, male)*

The focus was on mandatory formal training for HIM practitioners.

*Even if people are employed without the required academic training, policy leaders need to make training mandatory after a certain period of employment. Policy leaders also need to put a new health information system in place. ... There can be a partnership with HIM practice leaders to develop the policies that HIM practitioners want the Ministry to implement (Practice Leader 5, female).*

Continuing, she suggested enhanced promotion of the course of study to attract more interests and other measures for continuing education.

*Academic leaders should raise the intake of persons who are trained. Maybe there can be a partnership with the academic leaders and the HIM practitioners to go into schools to promote the courses of study. Put in place activities for continuing education. Academic leaders can also provide consultation or advisory to the HIM Administrators (Practice Leader 5, female).*

Additionally, there is the need for more:

*Communication and collaboration between the two entities [policy leaders and academic leaders]. From [the academic leaders'] level, communicate with the policy leaders to help them bridge the gap ... possibly scholarships to make it more attractive to study in the field. Policy leaders] need to buy into [the training institution's] offering and possibly get more [financial] support from [external stakeholders] ... Also, policy leaders should develop a policy for standardisation of study leave offerings (Practice Leader 6, female).*

Interviewees continued to echo similar sentiments and suggested additional strategies to bolster the points made. For example,

*We can contribute by doing the necessary research that would provide evidence to demonstrate to senior administrators that having HIM professionals at a certain level can enhance the efficiency and quality of service delivery, and save the institutions*

*money. We can also join advocacy with the professional groups to provide training in continuing education to enhance professional development so HIM professionals can be more proficient as we go along. Policy leaders can be more creative in terms of remuneration, such as short term training, on-the-job training, and conference attendance. Basically, creating more incentives to keep HIM practitioners motivated through externship, fellowships, exchange programmes with international organisations, and other capacity building activities (Academic Leader 1, female).*

Another suggestion was introducing leadership and management training and related policies.

*If academic leaders can identify strong students within the class they can help to build those persons. Maybe put in place some management training, leadership training like introduction to leadership and how to manage persons. I don't know if that's a part of the HIM curriculum but that could be a part of it... to identify potential leaders and train them to become leaders especially with the people skills needed to manage people – the most important resources.*

*Policy leaders – need to ensure that HR knows ... the policies of the department. HIM practitioners need to work with HR and come up with their policies ... and state their position in terms of the trained staff they need for the department, and stick to it (Academic Leader 2, female).*

Another area of focus was on strengthening the HIM professional association so that the members could realise different benefits from it.

*Policy leaders should seek to strengthen the association so persons can feel that there is benefit to be gained from it and can build and become a professional body where they can register, contribute [fees] ... and get a loan or some benefit through them once you are a member...*

*Academic leaders – In regards to the fee, could try to work out something where full tuition is paid through an MOU ... (Academic Leader 3, male).*

An additional suggestion was that policy leaders should work in unison with academic leaders to revise the HIM formal curricula to ensure currency and relevance, and to meet national and global demands.

*Policy leaders should ensure policies of parity and equality among the professions and that recognition is given to the importance of HIM in the delivery of health care. Academic leaders should ensure that they continue to train at optimum standard, continue to ensure that our courses are relevant and current and accredited. As part of maintaining that quality, ensure that our training modules are revised and reflect trends not only in Jamaica but also globally.*

*Perhaps the institution need to be looking at a system of continuing education and professional development and make these CEs available outside of the formal training and perhaps ... training for persons who are aspiring to become managers in HIM. Both could enter into some MOU perhaps. Perhaps also, specific training for persons who are aspiring to HIM leadership positions. (Academic Leader 4, male)*

These suggestions were supported with some expansions.

*The development of a comprehensive manpower plan with emphasis on groups like the HIM professionals should go some way to addressing the issues faced. The challenge will be with the benefits given the state of the Jamaican economy and improving training and working conditions. (Policy leader 1, male)*

There is also the need to fill the resources gaps.

*For succession planning, academic leaders could recommend a pool from which the Ministry could select through a competitive process. Policy leaders could address the issues of untrained staff by providing scholarships (even though we know those are scarce resources), and address the working conditions especially at the operational level. Provide the necessary resources, tools, automation, ICT type systems to make the work a little easier. There is need for more interaction between both [policy and academic leaders] to upgrade the untrained persons. That is, to aid with retention. (Policy leader 2, male)*

Additionally, it is important for policy and academic leaders to address issues related to the working conditions and the health information system; while the HIM practitioners put more worth into their work.

*Policy leaders need to look at computerizing the system – electronic processes could help to address problems such as working conditions. ... Stop putting just anybody in the department and put measures in place to ensure that recruits are thoroughly oriented before putting them in the department. HIM individuals need to put a little more [meaning] in their work; and see themselves as a critical part of the health team. (Policy leader 3, female).*

The data suggest that for recruitment, policy leaders need to address the issues presented some of which may be effected through development of policy for mandatory actions.

To aid with retention, policy leaders need to ensure policies of equality and impartiality, as well as inclusion and nondiscrimination among the professions. For succession planning, policy



leaders can pursue the development of policies to standardise study leave offerings, internal capacity building initiatives, mandatory leadership training, and the other procedures/activities previously discussed. In addition, policy leaders need to buy into the training institution's offering and possibly seek to get more support from external stakeholders for HIM professional development.

For succession planning, academic leaders could pursue more accessible means to offer the formal training courses and continuing education to enhance professional development of HIM practitioners. Academic leaders could conduct research and provide consultation to the HIM policy leaders and practitioners, and other stakeholders. However, all these efforts would require more synergy among both academic leaders and policy leaders.

*Summary of Research Question 3.* To summarise this section of the results, careful assessment of the content of this chapter demonstrate that there are a number of expectations that interviewees have of policy leaders and academic leaders regarding what they could do to address the challenges of recruitment, retention, and succession planning among HIM practitioners; and it requires joint efforts from both these groups of stakeholders to address these challenges.

The next section addresses Research Question 4. It entails possible roles that external stakeholders play in the recruitment, retention and succession planning in HIM in Jamaica.

**6.3 Research Question 4 Analysis.** In relation to external stakeholders' involvement in the processes of recruiting, retaining, and succession planning among HIM practitioners in Jamaica, some interviewees expressed unawareness of any such involvement while others responded:

*Not on a large scale. I am not seeing much of that in my setting. Most times they would come to ask if you can employ someone in your department but ...*

*I see where PAHO/WHO has had keen interest in the profession. At some point in time there were discussions about funding for training (Practice Leader 6, female).*

*Recruitment – On occasions, I would ask the staff and students [at the training institution] if they know of students who are unattached to any facility and if they are seeking employment. So, yes, [the training institution] in that regard.*

*Succession planning – Only invited guests to make presentations in meetings  
What I would like to do though is to forge alliance with [the training institution] to get trained staff (Practice Leader 2, male).*

Academic leaders were not aware of external stakeholders' involvement in recruiting, retaining, and succession planning of HIM practitioners in Jamaica. They further expanded that:

*The framework is there for that to happen. That is why we have the advisory committee in the academic institution, but outside of that ... no. The private sector is grossly underrepresented. The reason could be lack of awareness (on their part) of having people with these competencies who can positively impact their processes. (Academic Leader 1, female)*

There was doubt that external stakeholders were involved in recruiting, retaining, and succession planning of HIM practitioners in Jamaica because:

*On two levels, I am not seeing the interface that ought to happen or could be better, or could even be realised between health institutions and training institutions. I am not seeing that engagement and it's a missed opportunity on their part. (Academic Leader 4, male)*

Apart from HIM practitioners and the training institution, there was no other evident engagement from other stakeholders and:

*... by virtue of [the HIM practitioners] not having a strong relationship with the training institution, they miss the rate at which they can engage with the general public or other professional groups that could help to build the profession. (Academic Leader 4, male)*

Regarding succession planning, it was noted that efforts to engage stakeholders were lacking on the part of HIM leaders. Further, if there was any effort to engage, it was not evident and the HIM leaders needed to be more purposeful in their approach because:

*These stakeholders are not going to run to the institutions and say I have some money, I want to train these persons.... The initiation has to come from somewhere and I am just*

*not seeing it. So, it is the lack of the initiation or engagement by the HIM [practice leaders in the] institutions. (Academic Leader 4, male)*

The views expressed by policy leaders were similar to that of the academic leaders.

According to policy leaders:

*I don't know of any external stakeholders playing a role in the recruitment, retention ... of HIM professionals. This support is mainly in capacity building. PAHO has been a major partner; and to a much lesser extent STATIN has provided assistance in the past. (Policy leader 1, male)*

Another shared that:

*External stakeholders are in the recruitment process only as part of the interview panel (Policy leader 3, female).*

In addition, as stated earlier by Policy Leader 2, some sort of needs assessment was done by one external stakeholder organisation; and having identified certain training needs, support was given toward capacity building.

*Succession planning. PAHO plays some roles in capacity building. Exposing leadership to, you know there are various workshop and conferences and so they discuss matters related to HIM ... ICD-10 coding and those sorts of things. Exposure to HIS workshops and so on. There is no [other] external stakeholder (Policy leader 2, male).*

*Summary for Research Question 4.* The above data show that there was minimal involvement of external stakeholders in the recruitment, retention, and succession planning among HIM practitioners in Jamaica. Their involvement was mainly in the form of capacity building and still to a lesser extent, recruitment.

The next question concerns the availability of policies and procedures, how these were communicated to the HIM staff, and the relevance and currency of these policies and procedures in the HIM practice.

**6.4 Research Question 5 Analysis.** What policies and procedures are in place to guide HIM orientation, training and practice in Jamaica? This section of the results begins with the policies

and procedures used to guide HIM, then into how these policies and procedures were communicated to the HIM staff, through to whether the policies and procedures that were being used were relevant to the practice and up-to-date.

*Sub-category 5: Policies affecting HIM.* As participants have all gone through the employment process and are now practicing HIM, one could easily assume that they would have had some awareness of the policies regarding academic requirements for entry into the HIM profession. Although, the majority of participants reported that they were aware of the policies regarding academic requirements for entry into the HIM profession, there is still a concern regarding the 23% who reportedly disagreed or who were not definitive with their responses.

For the item (Q36) that addressed participants' awareness of the policies regarding HIM training, the total affirmative responses were almost 66%; and the negative responses were over 13%, while the undecided responses were also 13%. Almost 55% of the staff reported that they have been oriented to the policies regarding HIM training. Just under 22% were in some level of disagreement, while 23% were undecided. Participants' responses to their "awareness of" and "orientation to" the policies regarding HIM training were fairly consistent with a slightly higher percentage reported being "aware of" than those who were "oriented to" these policies. See Figure 6.2.

In relation to the item, that addressed participants' awareness of the policies and procedures for the HIM practice, the total affirmative responses were almost 65%; and the negative responses were over 13%, while the undecided responses were 20%. The next item concerned whether participants had been oriented to the policies and procedures for HIM practice. Just over 58% were in some level of agreement, 19% in some level of disagreement, and 21% were undecided. Participants' responses to their awareness of and orientation to the policies regarding

HIM practice differed slightly but for the most part were consistent except for one response where the “awareness of” was lower than “orientation to” which should have been the same if “awareness of” was not higher. The last two items in this sub-category, concerned the relevance and currency of the HIM procedures and policies to the HIM practice. As Figure 6.2 demonstrated, 71% returned a positive response, under 5% gave a negative response, and 24% were undecided.

A cumulative 37% of participants agreed that the HIM procedures and policies were current and up-to-date. On the other hand, in total, just over 16% disagreed and an alarming 46% offered an undecided response. Responses provided for these last four items in this sub-category were somewhat difficult to unravel. Note that 65% reported that they were aware of the procedures and policies guiding the HIM practice, while 58% said they were oriented to these procedures and policies. This is fairly understood as the staff can have knowledge of these without being oriented to them. However, if 65% reportedly knew of these procedures and policies, how could 71% of participants, 6% more than those who were aware of them, then report that these procedures and policies were relevant to the HIM practice? Further, if as participants reported, 58% of the staff have been oriented to these procedures and policies, how could 46% of participants not be in a position to say whether these procedures and policies were

current and up-to-date?

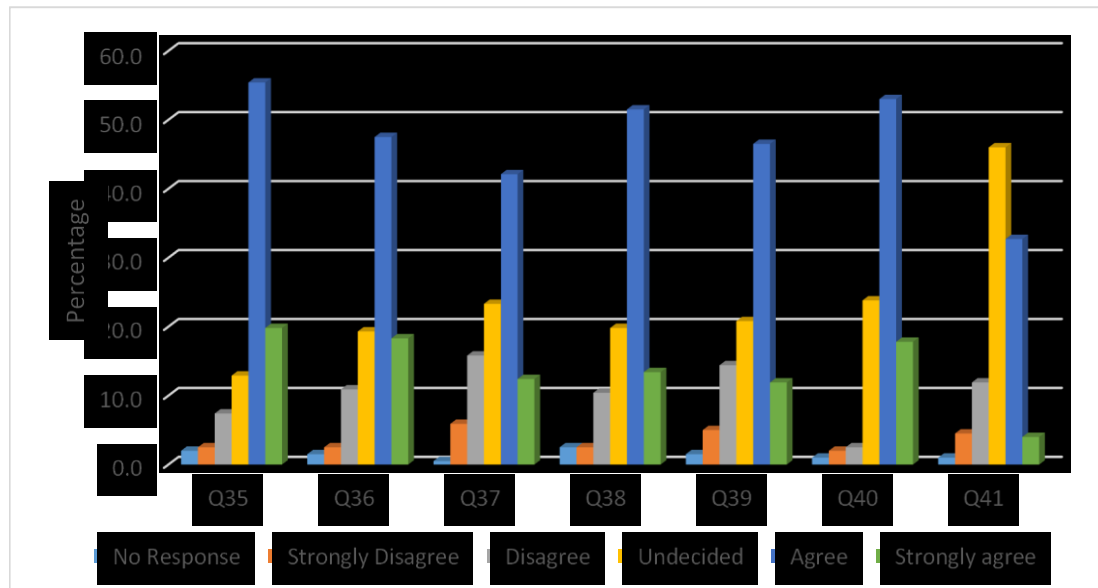


Figure 6.2 Percentage distribution of responses for items in Sub-category 5.

As highlighted in Figure 6.2, which addressed procedures and policies in the HIM practice, affirmative responses to the first six items (Q35 – Q40) ranged from 55% - 75%, undecided ranged between 13% - 24%, while the percentage that disagreed ranged from 5% - 22%. Responses to the last item (Q41) were obviously dissimilar with almost 37% in some level of agreement, a high of 46% undecided and 16% in some level of disagreement that the HIM policies were current and up-to-date. The undecided responses were highest in this sub-category

To summarise, the responses to these last Likert-type items were fairly consistent except for responses to participants' "awareness of" and "orientation to" the policies regarding HIM training where a slightly higher percentage reported being "aware of" the HIM policies and procedures than those who were "oriented to" these policies and procedures. The other inconsistency was identified in the responses to the seventh item (Q41 in this sub-category,

where a high of 46% were undecided about whether the HIM policies and procedures were current and up-to-date. These inconsistencies posed some challenge interpreting the results but the interview data helped to provide clarity.

***Availability, relevance and currency of HIM Policies and Procedures.*** The final question posed to respondents was about the availability, relevance and currency of HIM procedures and policies specifically guiding their training, orientation, and practice. This three-part question sought to determine whether there were established procedures and policies regarding HIM training, orientation, and practice. If there were policies and procedures, how they were communicated to the staff, as well as the relevance and currency of such procedures and policies to the HIM practice.

According to interviewees, general training policies existed but there was none specific to HIM staff. Also, while policy manuals were in place to guide the HIM practice, there were no established procedures and policies in place for HIM orientation. One interviewee reported:

*I am not aware of any set policy regarding orientation.* (Practice Leader 2, male)

However, it was reported that some facilities had documented orientation guidelines or programmes in place while other departments had no specific documentation regarding orientation in place and senior HIM staff basically employed different means to orient their staff. HIM practice leaders reported:

*... we have an orientation process in place. I personally have put together an orientation document – it is not finished but I am working on it.* (Practice Leader 3, female)

Another response was that:

*The department has orientation programmes. There is a training policy but it is not specific to HIM* (Practice Leader 5, female)

The above responses begged some sort of regularisation of procedures and practices.

*Yes [there are procedures in place] but standardisation is lacking. We are not standardising our practices and I think that is our downfall. So we need standardisation.* (Practice Leader 4, female)

Similar feedback came from academic leaders who indicated that there were no standardised way of doing HIM orientation. Instead, the senior HIM staff did what they thought was good or effective enough get the message across to their new recruits. Therefore, HIM orientation was not standardised but there was the belief that:

*There is a standard guideline that is developed and outlined over the years and this is packaged to the recruits during orientation.* (Academic Leader 1, female)

Further,

*There should be established orientation plan and work flow plan that are used in orientation* (Academic Leader 2, female)

While there were general training policies in place, there were no established policies and procedures in place specific to HIM training and orientation. Concerning the practice,

*I am sure there are policies in place but the [staff in the particular area of the] Policy Unit can speak more definitively on [the content and how it is communicated to the staff]* (Policy leader 3, female).

And as one interviewee expanded, not enough policies and procedures were in place for HIM training and this argument was grounded in the fact that there was none specific to HIM training. He also argued for a change and added that there was not enough public orientation to the profession. Furthermore,

*I am not seeing a HIM section on the Ministry's website or on any RHA's website so definitely enough is not being done there.*  
*In relation to practice – I don't think enough is done. As far as I know the very procedures manual that is there was written years ago by [the then senior HIM director] which is now grossly inadequate because that's 15 years ago and there are so many changes in the profession since then.... Enough is not being done regarding procedures and policies for these three items that are there.* (Academic Leader 4, male)



These results reinforced the point that there were no policies and procedures in place specific to HIM orientation and HIM training. However, established policies and procedures, though dated, were in place for the HIM practice.

***How policies and procedures were communicated to the staff.*** Working in the actual field, the practice leaders were in the best position to say how the policies and procedures guiding the HIM practice, were communicated to the staff. They shared that while there were a number of ways in which these policies and procedures were communicated to the staff, these were mainly communicated during the initial orientation to the job. Interviewees reported that in some instances, the new recruits were merely given the procedures manual to read and inform themselves.

*When they [new recruits] come in the first couple of days, they have the manual go through and they get the opportunity to ask questions. When they start working and things are not clear, they can always come back to the supervisors to get clarification. I ensure that they all know the manuals are available at any time. (Practice Leader 3, female)*

In addition,

*The [new] staff members read the manuals and take notes... and the supervisor will assess them on what they have read. If there are any areas that they are not clear, they go back to the manual or ask the supervisor. (Practice Leader 1, female)*

In other instances, efforts were made to ensure that the information was directly communicated to the staff during staff meetings, in-house training, and in one-to-one interactions. In addition:

*We let the staff know that it is available and we encourage them to read it and empower themselves. (Practice Leader 2, male)*

*Each department is given a copy of each manual and all the policies. The information is communicated to the staff] through workshops. (Practice Leader 6, female)*

Also, regarding how the information was shared,

*The information is communicated in writing via the health management manual and job description; and orally by other members of staff – more senior persons (Academic Leader 3, male)*

Others noted that the information in the procedures manual was communicated to the staff in different ways but mainly through workshops and training sessions that were organised by the [HIM] Unit within the Ministry of Health.

*There are also policy documents/ manuals which are also circulated to the relevant Regional Health Authorities. (Policy leader 1, male)*

*There has been organised training to expose, I think, staff at the operational level to system changes, procedural changes and so that is there... Maybe [the information is communicated through] workshops and supervisory visits (Policy leader 2, male)*

In other instances, it was unclear how these policies were communicated the HIM staff.

*I don't know that the time is taken to do that [to properly communicate procedures and policies to the staff] and I have not gotten feedback [in this regard] (Academic Leader 4, male)*

As the data revealed, there were no established ways of sharing the information regarding HIM policies and procedures with the HIM staff.

***Relevance and currency of HIM policies and procedures.*** In relation to the relevance and currency of the policies and procedures that were used to guide the HIM practice, interviewees unanimously reported that there were established procedures and policy manuals in place. They expanded that much of the content in the manuals were relevant to the practice because the information was still being used. Interviewees added that the HIM procedures manual was developed over 15 years ago (Ministry of Health, 2002), but so many changes have taken place in the HIM practice since then. Hence, much of the information in this manual was dated rendering it inadequate to guide some aspects in the current HIM practice. Therefore, the

manuals needed to be revised and updated to reflect current trends. The content was relevant to an extent but:

*... With what is happening now, in terms of the fact that we are in the IT age and when you look at systems overseas, we are behind. So they still need to be revised to align with current practices locally and internationally. (Practice Leader 3, female)*

*Processes change so the procedures manual [needs some change as well] ... I don't see anything in it regarding certain new procedures so it needs updating to reflect current processes (Practice Leader 5, female)*

But, this was also affected by inconsistencies in the practice.

*... There needs to be standardisation to ensure uniformity ... [the policies and procedures] need to be improved and each stakeholder needs to have a say in the upgrade of these policies. There needs to be improvement but they are still valid. For example, [some content] in the manual are similar to what [our international partners] are still doing. It's just that we are not standardised across the regions (Practice Leader 6, female)*

Academic leaders all agreed that the information in the HIM procedures manual was somewhat relevant because some of the HIM functions have not changed but some of the information was definitely not current so it needed to be revised. They shared that:

*The practice has not changed much over the years but this is gradually changing. So, most parts of the manual would be relevant but it is not as current as it should be. It should be updated to reflect manual and electronic processes. (Academic Leader 2, female)*

But another interviewee was careful to point out the inadequacy of the procedures manual to guide the current HIM practice because of how dated the content was.

*As far as I know the very procedures manual ... is very old. [It is now] grossly inadequate because there are so many changes in the profession .... They are definitely not current but [some aspects] could remain relevant. (Academic Leader 4, male)*

And:

*I don't think the manual has been updated in recent times... or else I would have been aware of it. So maybe it is in need of updates. There may be aspects of it that are still relevant. (Policy leader 2, male)*

Others shared that with regards to relevance and currency of these policies and procedures:

*The policies are still relevant for the actual practice of the HIM professionals. However, we have seen the need to update the information to keep in line with current trends. (Policy leader 1, male)*

However,

*They are currently in the review process. (Policy leader 3, female).*

The data revealed that there were no established policies and procedures in place specific to HIM orientation and training. However, due to the number of changes in the HIM profession, since the procedures manual was developed, the policies and procedures that were in place to guide the practice were relevant only in part and the information was not current. The documents needed to be revised to include both manual and electronic processes and to reflect current HIM practice.

*Summary for Research Question 5.* The responses provide meaning into and the relevance and currency of the policies and procedures guiding the HIM practice in Jamaica.

Based on these results, it appears there were no policies and procedures in place that were specific to HIM orientation and HIM training. However, established policies and procedures were in place for the HIM practice but they were dated. Also, there were no established way of sharing the information regarding HIM policies and procedures with the staff. These responses call for urgent actions to overhaul existing policies and develop new ones to guide the HIM practice; and to establish documented standards for related information sharing.

## **6.5 Chapter summary**

There was no established HIM succession plan in place but in some instances there were what appeared to be pockets of succession planning. A number of strategies were suggested to address the various challenges identified regarding recruitment, retention and succession planning in HIM in Jamaica but this requires joint efforts from all stakeholders. The practice lacked standardisation and there is need for relevant and current policies and procedures to guide HIM training, orientation, and practice.

The next chapter gives an interpretation made from the literature and analyses of chapters five and six.

## **Chapter 7 - Discussion and Evaluation**

### **7.1 Overview**

Leading successful organisations requires continuous engagement of stakeholders in dynamic and meaningful relationships aimed at realisation of the organisation's goals (Daft, 2010). As human resources are an organisation's greatest assets, each organisation needs to ensure that structures and systems are in place to attract, retain and develop their human resources. Much of this can be achieved through effective people leadership (Miller, 2016). While some people have inborn leadership qualities which are easily developed; others have to learn and adopt these qualities. Also, while not all managers are leaders, all leaders are managers. However, for an organisation to benefit from leadership, the process must be effective. It was over 20 years ago that Huffman (1994) stated that effective leadership involves a balance of interests in both employees and organisational outcomes. Furthermore, "the quality of an organisation's leadership has a considerable influence on its employees' effectiveness" (Al-Zefeiti, & Mohammad, 2015, p.1). Effective leadership therefore requires being proactive and appropriately equipped to participate in purposeful decision making; and developing others to function just as effectively; to strengthen relationships, build trust, foster innovativeness, encourage commitment, challenge the status quo, and build competencies (Johns, 2002).

This chapter delves into the results of the survey and interviews, juxtaposes both responses; and compares both with the literature to generate an interpretation. This discussion follows a pattern that analyses themes and it begins with leadership practices among HIM practitioners. The discussion progresses throughout according to the themes identified from the data, and culminates with the final theme that addresses policies and procedures in HIM. This chapter is

arranged according headings and these headings are based on the themes identified from the data collected. Table 7.1 illustrates the themes and sub-themes.

**Table 7.1:**  
***Themes and Sub-themes***

	<b>Themes</b>	<b>Sub-themes</b>
<b>1</b>	<b>Leadership styles practiced among HIM practitioners</b>	Leadership and management in HIM Recruitment & Retention in HIM Succession planning among HIM practitioners
<b>2</b>	<b>Challenges with recruitment, retention and succession planning among HIM practitioners.</b>	
<b>3</b>	<b>Roles played by HIM leaders in succession planning and the development of the HIM profession</b>	Roles played HIM leaders Measurement and assessment of roles played by HIM leaders
<b>4</b>	<b>Involvement of stakeholders in recruitment, retention and succession planning among HIM practitioners in Jamaica</b>	Academic and policy leaders' involvement External stakeholders' involvement
<b>5</b>	<b>Policies &amp; Procedures in HIM</b>	Availability of HIM policies and procedures Communicating HIM policies and procedures Relevance and currency of HIM policies and procedures

## 7.2 Theme 1 - Leadership styles practiced among HIM practitioners

In the same way there is no one fixed type or style of leadership that is suitable for any organisation, when it comes to leading HIM practitioners, there is no one-size-fits-all type or style of leadership (Miller, 2013b). Consideration must be given to a number of factors which include leadership preferences, the situation at hand, the culture of the people being led, and the context in which they are being led (Daft, 2010; Miller, 2018)). Therefore one must take careful note of these factors and always be cognisant that, as Miller (2018) argued, context shapes leadership and leadership shapes context. Furthermore, "the environmental context in which leadership is practiced influences which approach might be most effective, as well as what kinds of leaders are most admired by society" (Daft, 2010, p. 410). Based on the results of the survey, it was evident that no one leadership style was practiced and that varied leadership practices existed in the institutions where the participants worked, particularly among HIM practitioners. However, it appeared as though leadership was rived.

***Leadership and management in the HIM department.*** Overall, the responses indicated that elements of different types of leadership were being practiced, including democratic/participative, laissez-faire, charismatic, transactional, transformational, and distributed leadership; and in some instances, a hybrid of leadership practices. In other instances, it appeared that the prevailing leadership practices were not easily identifiable as a number of "undecided" responses were returned. This appears to be an outworking of the chaos theory (described in Chapter 2), where individuals in the HIM organisations were focused on their purpose and values rather than trying to explain leadership. This is consistent with the literature since Burns (2002) argued that leadership that done along with chaos theory is easier to practice



than it is to understand. However, results of the interview confirmed that leadership was fragmented.

As highlighted in Chapter 5, for the items that were aligned to professional development and capacity building, the highest percentage of staff that were in some level agreement was below 50%; and approximately 51% reported that leadership in their institutions both inspired and motivated the staff and allowed them to participate in decision-making. These responses aligned with the interview responses and were evidences of how they described the leadership practices in HIM in Jamaica. Further, the 55% of participants that expressed willingness to take on leadership roles indicated, as Hopkins and Higham, (2007) described it, an air of systems leadership. But, in this situation, more HIM practitioners were willing to take on leadership roles than those who were actually given the opportunity to participate in leadership. While this was so, 44% of participants reported that leaders in their institution encouraged staff members who were never involved in leadership activities to take on leadership roles. Could this mean that there were not enough opportunities for the HIM staff to participate in leadership? Again, this may have been attributed to the different types of leadership styles practiced by HIM practitioners, as reported by interviewees.

From the qualitative data, some leadership practices and styles of leadership were recurring more often indicating an amalgamation of leadership practices in HIM in Jamaica. This corroborated what was found in the literature, since, as provided by Daft and Marcic, (2012), successful leaders engage in multiple leadership practices and styles from various sources to effectively execute their roles. The response of Practice Leader 2 substantiated the 41% of survey participants who reported that leadership focused on the work more than people, gave little attention to the staff, and was more task and goal-oriented so their emphasis was primarily

getting the job done. From this, it was clear that transactional type of leadership was also being practiced as according to the literature, transactional leaders focused more on tasks, job functions and requirements for the job more than the welfare of the staff (Odumeru & Ogbonna, 2013).

Harris and Spillane (2008) argued that leadership is better affected using a collaborative approach and recognising individuals for their efforts. While it is important to realise organisational goals, HIM practitioners are vital to such achievements and should not be slighted so they get the feeling that all that matters to leadership and management is the job. Rather, it would be more beneficial and mutually rewarding for HIM leaders and managers to share the burden of leadership (Smith, 2013); and to adopt more communal types of leadership such as transformational and distributed leadership (Fullan, 2004). Transformational leadership would have HIM practice leaders identifying energies in their staff, seeking to satisfy the needs of their staff, and fully engaging them (Guay, 2011); while distributed leadership would have HIM practitioners honing specific qualities and merging those talents to provide leadership within their group or organisation (Harris, 2008).

*Identifying people to fill HIM leadership positions.* Sheridan, Watzlaf and Fox, (2016) underscored the importance of purposefully and intensely grooming and training leaders in the HIM profession. Over 57% of participants in the survey reported that the HIM staff was willing to take on leadership roles, and over 61% agreed that there was evident leadership capacity in the existing HIM staff. However, less than one-third participants reported that it was easy to identify people to fill HIM leadership positions. Through the interviews, it was established that the challenge identifying these capacities was due the inadequate number of trained personnel to assume leadership roles. The findings here dis-align with the recommendations of Sheridan,

Watzlaf and Fox to groom and train; and provide evidence that such grooming and training of HIM leaders was not being done in the Jamaican setting.

As described in Chapter 3, one could argue that practitioners were deprived of the related practical experiences and were not aspiring for leadership (Rubenstein, 2014) as they should have been. However, strategies to resolve these issues were not far-fetched. Aspects of several theories and proven practices could be applied such as learning leadership by doing leadership (Keeton, 1983; Schank, Berman, & Macpherson, 2013); learning with and from one another (Fullan, 2004); converging interests (Bell, 2009); and distributing leadership (Harris & Spillane, 2008). In addition, there can be more engagement of practitioners through transformational leadership (Arnold & Loughlin, 2013; Basham, 2012); and more effective people and practice leadership (Miller, 2018).

Interviewees shared that over 50% of HIM staff were not academically trained and even some who were trained, did not possess leadership skills hence they were not in a position to assume leadership roles. However, in some instances, the staff were both academically trained and possessed leadership capabilities but were reluctant to assume leadership roles. This is an interesting paradox that people do not want to lead or manage. Again, this is an area where effective people leadership (ibid) is warranted; and where more investigations should be done. In the meantime, HIM leaders and managers must seek strategies to develop leadership capacities and the willingness to lead. One such strategy could be distributed leadership. Spillane (2009) exposed that distributed leadership “allows for the possibility that anyone in the [organisation] may take responsibility for leading and managing” (p.72), and as elucidated by Greenfield, Braithwaite, Pawsey, Johnson, and Robinson (2009), HIM practitioners would be interacting and sharing expertise which would lead to learning while building capacity. Further,

as Hill-Berry (2015) submitted, by distributing leadership, organisations can continue to build leadership competencies, so this may be a path that HIM leaders and managers need to tread.

Abrams, Giannangelo and Schneider (2014) suggested filling and resolving HIM leadership gaps through mentoring to provide opportunities for HIM practitioners to develop leadership skills and to gain meaningful insights from the more experienced; and as agreed by Schank, Berman, and Macpherson (2013), this medium could create opportunities for them to practice leadership. In addition, if HIM leaders embrace mentoring and practical experience, they could involve their staff in leadership activities that advance their efficacy and build their competencies (Lavery, 2016). By extension, the organisations would benefit since they would be equipped with the skills and competencies that they need to function effectively. Thus, there is a triple lock of benefits to be derived from organisational mentoring.

As demonstrated in Chapter 5, both survey participants and interviewees reported challenges identifying practitioners from the field to assume HIM leadership roles in the training institution in Jamaica, as these talents could not be readily identified. However, Academic Leader 1 and Policy Leader 2 presumed they could identify specific leadership skills or qualities that could be groomed but this identification would be based on observation of HIM practitioners' demeanour while in training. This is problematic for two reasons. One, it reifies the point that there is no clear system of succession and capacity development in the Jamaican HIM context. Two, leaving the identification of future leaders to individuals is fraught, and can only add to perceptions of nepotism and corruption, already steeped in the system (Miller, 2013a); and more widely in Jamaican institutions (Miller, 2014).

The mentioned challenges identifying people to fill HIM leadership positions may also have been compounded by the recruitment, retention, and succession planning challenges, all of which are discussed below.

***Recruitment & Retention in HIM.*** The recruitment process is a thorough one which involves job analysis through to selecting the best talents (McWay, 2014). In any organisation, before initiating the process, it is important to have an understanding of its recruitment and selection policies (Fuller, 2007). Recruitment should therefore be a clearly established and formal process. However, from the research evidence, there was no specific or formal way of recruiting HIM practitioners in Jamaica. While 50% of participants in the survey agreed that their department adhered to established methods for recruiting HIM staff, only 25% shared that their department was usually timely with recruitment. In terms of how the recruitment was done, interviewees reported unstandardised and tainted processes detailed in Chapter 5.

The situations described by interviewees communicated that HIM organisations were biased in executing some roles (Bozer, Kuna & Santora, 2015); and were engaging in practices that were inconsistent with professional standards, and detrimental to retention (Spence Laschinger, Leiter, Day, & Gilin, 2009). Further, these ad hoc means of recruiting certainly could not have allowed HIM organisations to select the best talents (McWay 2014). There were also issues of quality and transparency; but as Miller (2014) advanced “corrupt practices in recruitment and selection must give way to transparent practices” (p. 135). Therefore, the other pertinent question is, how can HIM organisations ensure transparency and quality in their leadership practices? This meddling is destroying the fibre of HIM in Jamaica as any interference in recruitment and retention is tantamount to corruption. In the interest of non-maleficence and sound practices, such interferences must be forefended. In addition, these poor recruitment

practices could lead to other types of retention issues where staff feel they can do as they please and remain unmoveable because of their acquaintances (Miller, 2013a).

As a response to current recruitment and retention issues, HIM organisations in Jamaica should pursue transparent strategies including ‘growing your own’ as the number one method of recruitment and retention (Wood, Finch, & Mirecki, 2013); and should engage in proper leadership development initiatives such that those subsequently engaged in the recruitment process can select the best candidates who will move the organisation forward (Bozer, Kuna & Santora, 2015). In addition, as a means of human capital development, Jamaican HIM organisations and the government need to invest in HIM training to advance their knowledge, skills and educational capacities (Piper, 2012); and to realise more economic benefits (Becker, 1993) for the country.

While there is need for investment in human capital, there is a challenge as HIM in Jamaica is not a profession that is bound by clear recruitment and employment standards; and a lot of the progression opportunities reflect wider practices within the environment – both within HIM and outside of HIM. Even if there are established frameworks in Jamaica, the social network is far more dominant in recruitment and progression than any formalised structure. It is less about what you know but who you know. In Jamaica, it is not the human capital that gives one the promotion, it is social capital. This is akin to what Miller (2013a) described as corruption as redemption – which is really about social capital being the rubric for progression rather than cultural capital (Miller, 2014; Miller, 2013a).

*Fulfilling job.* Of the survey participants, 57% reportedly found their job fulfilling and felt valued being HIM practitioners. Interviewees linked the other 43% to people using HIM as a stepping stone into other professions and simply waiting for an opportunity to leave, lengthy

delays in staff appointment, lack of recognition, and practitioners' perceptions of their work and worth. But, people's perception about whether their job is fulfilling is often linked to how much their worth is recognised and their professional identity. While not discounting any of these concerns, Jamaican HIM practitioners need to own their professional identity. As Thomas-Gregory (2014) shared in the literature, an individual's professional identity is usually formed during initial orientation and gradual socialisation into the profession. In the HIM profession, this gradual process of identity formation can be delayed based on the nature of the profession and the recognition issues that interviewees mentioned, and more specifically practitioners' values, how they feel about their professional roles (Slay & Smith, 2011), and the worth of their work.

HIM practitioners' ownership of their professional identity should result in new approaches to the professional development activities they engage in, attitudes about their profession, their attitudes towards the services they deliver to their clientele, and the groups with which they associate (Hayden, 1991). As proper construction of professional identity is often linked to career success (Slay & Smith, 2011), HIM practitioners first would need to demonstrate positive attributes and values that relate to how they define themselves in their professional roles (Schein & Schein, 1978). This would help them to hold certain values and have a sense of belongingness and fulfilment with which they could socialise into the professional community and ascribe to the high status that they are truly worth (Hotho, 2008).

*Retention.* While 51% of participants agreed that employee retention helped the development of their department, over 75% reported no measure in place to retain HIM practitioners. It appears that while participants were aware of the value of employee retention, staff turnover was still high due to the absence of retention strategies and other causes such as poor working

relationships, unattractive salaries, and the feeling that no one listened to their concerns and suggestions. Additionally, since 57% agreed that they found their job fulfilling and felt valued being HIM practitioners, it could be interpreted that the 43% who disagreed or were undecided were the ones who were leaving.

Just over 50% of participants in the survey agreed that communication was excellent in the HIM department. While one could reasonably assume that on average, communication was excellent within the HIM department, it appears that there were communication issues as those who agreed, coupled with those who were undecided totalled 50%. As Practice Leader 5 shared, the relationship with supervisors was often unhealthy and at times that caused separation from the organisation. More investigation would be required to determine if the high level of attrition interviewees mentioned was specifically related to communication in the department or to other issues mentioned above.

As Policy leader 3 shared, no discussion had been held regarding a retention policy or measures to retain HIM practitioners in Jamaica. However, the literature offered some approaches to strengthen retention such as HIM leaders working closely with HR departments to identify strategies that “keep valuable employees from seeking employment elsewhere” (Fuller, 2007, p. 893), engaging in initiatives to boost their morale and productivity (Rothwell, 2010); and promoting high staff morale, professional development, and employee personal commitment (McWay, 2014). In addition, all parties must work together to ensure suitable work environment (Spence Laschinger, Leiter, Day, & Gilin, 2009), because considering the “time, and money invested in hiring, orienting, and training an individual, it is in an organisation’s best interest to take steps to keep the individuals on staff” (McWay, 2014, p. 365).



***Succession planning among HIM Practitioners.*** Approximately one-third of survey participants were in different levels of agreement regarding efforts made towards succession planning among HIM practitioners. Of particular note was that 30% of participants agreed that their department was active in identifying potential talents in HIM practitioners and developing staff to fill HIM leadership positions; and 35% of participants agreed that the next head of their department was likely to be identified from within. This is another area of concern for HIM leadership and management because if potentials are not being identified, how will strategies be put in place to develop the staff? And what will this mean for the future of HIM leadership? The low percentage of affirmative responses above highlights another issue to be addressed by HIM leadership and management in that succession planning should be done to ensure that when staff members are promoted or separated from the institution, the gaps can be easily filled (Pinnix, 2015; Olson, 2008).

Interviewees shared that there were nips of succession plans that were specific to their departments or health region and that involved mainly HIM leaders and managers subjectively targeting their ‘best fit’ staff to understudy those nearing retirement; and on rare occasions, as a means of replacing those who were migrating or had been promoted. While academic leaders stated they were unaware of any established HIM succession plan, policy leaders affirmed that there was none. Both data sets indicated that no established succession plan was in place for HIM practitioners; and what some referred to as succession planning was basically pinpointing specific individuals and grooming them to take over whenever someone was separating from the organisations – mainly via retirement. However, nothing was in place to fill gaps that may become vacant when others were promoted or resigned. One could not deny that there may have been pockets of succession planning. However, nothing was in place to ensure professional

development and capacity building to equip practitioners for any transition regarding upward mobility.

The current HIM practice in Jamaica demonstrates the opposite of what meaningful succession planning ought to be. As was found in the literature, when succession planning is properly executed, when a practitioner is reassigned or separates from the organisation, the transition will be seamless (Olson, 2008). Likewise, HIM practitioners would be constantly learning and retooling thereby expanding their capacities to produce desired results (Senge, 1990). No doubt this reciprocal learning from within would offer HIM practitioners a sense of support, and enthusiasm for pursuing objectives. It would also allow both parties to develop habits that would be instrumental to their career as leaders and aspiring leaders in the HIM field (Trowers, 2016); and ultimately equip the organisation with the required talents.

### **7.3 Theme 2 - Challenges with recruitment, retention and succession planning among HIM practitioners.**

Leading and managing HIM organisations in Jamaica require keen attention to recruitment, retention and succession planning, identifying related issues, and employing strategies to resolve such issues in the interest of practitioners, departments, and organisations. As discussed in Chapter 5, some issues related to *recruitment* of HIM practitioners in Jamaica were that the number of practitioners that were being trained was always inadequate to meet HIM staffing needs so the need for these scarce skills was almost always permanent; HIM practice leaders were habitually hunting for HIM graduates; and too much time was spent orienting and training. Further, because of shortage of staff, the HIM and HR departments often reported challenges to release staff members for training.

*Retention.* According to the data, retention was affected by poor relationships with supervisors, the feeling that they were somehow side-lined by HR, weak leadership, and the lack of vision on the part of senior leaders to collaborate and create opportunities for the staff, and several other challenges described in Chapter 5. Due to inadequate number of posts for permanent appointment and other upward mobility issues mentioned by interviewees, HIM organisations were at times reluctant or unable to promote from within. Such inability or reluctance to promote from within also posed serious threats to retention. As the literature suggested, practitioners who get no opportunity for upward mobility within their organisations are less likely to stay; and when looking for upward mobility, those practitioners are more likely to seek opportunities outside their organisation (Bozer, Kuna, & Santora, 2015). The result of which is attrition.

*Succession planning.* Challenges related to succession planning were reported as lack of professional development opportunities. As Policy Leader 2 reported, no HIM succession plan had been developed so positions were not filled based on a succession plan. Rather, adverts were done and people applied so positions were being filled competitively. This should not give the impression that if there was a HIM succession plan, particular individuals would have been hand-picked for leadership positions. Instead, through succession planning, a number of employees who already were a part of the organisation and were familiar with its operations and practices would have been equipped as successors (Green, 2011; Olson, 2008). This internal talent development would have fortified the organisation with the right mix of talents and a new pool of leaders that the organisation could draw from using a transparent process (Pinnix, 2015).

#### **7.4 Theme 3 - Roles played HIM leaders in succession planning and the development of HIM profession.**

Effective HIM leadership requires adequate succession planning and meaningful engagement with the professional body. Interviewees reported that HIM practice leaders were playing minimal roles in succession planning and the development of the HIM profession. They reported informal roles played in the past but were unaware of current roles to move the profession forward. The data does not synchronise with the literature that describes performing succession planning roles toward equipping employees for upward mobility (Ellinger et. al., 2014; Heritage, 2011). The literature noted that succession planning can be a very costly but most rewarding investment (Rothwell, 2010; Fuller, 2007) for HIM organisations. When appropriately done, the returns of such investment are immense.

Interviewees' report gave evidence to Hill-Berry's (2015) description of the Jamaican setting in which there was "holding on to leadership" and stifling of the succession planning process. In the same breath, this is an indication that Jamaican HIM organisations do not embrace Bozer, Kuna, and Santora's (2015) position about organisations' leaders and managers facilitating succession planning by identifying upcoming leaders and engaging them in leadership development initiatives. Neither do they embrace Miller's (2014) suggestion of identifying and harnessing skills while seeking to build capacities and enhance professional development. Further, there was no leadership training or related professional development activities to equip aspiring leaders (McLean, Scale, & Rouse-Jones, 2016).

Interviewees shared what HIM leaders should be doing to ensure succession planning and the development of the HIM profession such as ensuring that they are good leaders and mentors, facilitating and engaging in continuing education, and rotating staff assignments. Their

suggestions are supported in the literature where Hill-Berry (2016); and Sheridan, Watzlaf and Fox, (2016) proposed pursuing various means to enhance succession planning. The question therefore is, if HIM leaders were aware that these measures should be in place, why were they not? Since the suggestion was made for those in leadership positions within the profession to understand the importance of succession planning (Academic Leader 1, female), is it that HIM leaders downplay the three-fold value of such a process to themselves, to their department and to their organisation as a whole? Further investigation will be required to provide answers.

Interviewees noted that, as managers of their department, HIM leaders must engage in identifying strengths and training needs of their staff, and consulting with HR department regarding meeting training needs. Among other things, interviewees added that HIM practice leaders must lead and manage appropriately. These were strengthened by Policy leader 3, (female) that HIM succession planning is an important matter that the professional body (Practice Leaders) and the Ministry (Policy Leaders) should be actively discussing with a view to having a succession plan for HIM practitioners. These recommendations are supported by the literature in terms of adherence to professional code and standards (Hill-Berry, 2016); synchronising succession planning and leadership development (Bozer, Kuna & Santora, 2015); and planned training and development activities for all employees as a means of equipping them as successors (Green, 2011).

***Measurement and Assessment of roles played by HIM leaders.*** Most interviewees shared that since HIM leaders were not playing the roles they should, no assessment or measurement of such roles was ever done. For others, there was uncertainty as to whether any such assessment was done although they agreed it was a necessity for any organisation that *wants to maintain a certain level of quality* (Academic Leader 1, female); but, any attempt to do such assessment or

measurement could be a challenge because no such initiative was undertaken prior (Policy Leader 1, male). The responses suggested that the minimal, informal roles played were not substantial enough to have been measured or assessed by any group of stakeholders.

Interviewees however shared a number of roles that health information managers should be playing towards succession planning and the development of the HIM profession in Jamaica.

Interviewees' expectation was that HIM practice leaders should synergistically lead initiatives to assume these roles and move the HIM profession forward. This calls for transformational leadership to change the status quo and to help HIM practitioners to connect with their profession because transformational leaders help people to create a bond based on their own example, their own buy in, and their ability to sell their vision for organisational effectiveness (Al-Zefeiti, & Mohammad, 2015; Bush, 2003) and effective practice (Leggat, 2009) .

#### **7.5 Theme 4 - Involvement of stakeholders in recruitment, retention and succession planning in HIM in Jamaica.**

Effectively leading and managing HIM require active and purposeful engagement of all relevant stakeholders (Bush, 2003). From the data, interviewees suggested a number of roles that academic leaders, policy leaders, and external stakeholders could play in the recruitment, retention and succession planning among HIM practitioners in Jamaica. These suggestions are discussed in the two subheadings following.

***Academic and policy leaders' roles in recruitment, retention and succession planning in HIM in Jamaica.*** Interviewees proposed that *policy leaders* need to: develop a comprehensive manpower plan for HIM practitioners, change the entry requirements into the profession, implement a policy to mandate entry level requirements and mandate specific training for practitioners who are already working without the requisite training; and ensure that recruits are

thoroughly oriented before assigning them any HIM task. Policy leaders should address issues related to infrastructure and the working conditions to attract more people into the profession. Policy leaders also need to revamp or develop policies for HIM orientation, training, and practice to ensure equity among the professions, transparency and standardisation of processes, and more creative means of incentivising practitioners for professional development. They also shared that policy leaders need to rigorously engage the relevant authorities to create more posts for permanent appointment and some form of job security.

The literature described the types of leadership required to drive organisational changes. Since HIM stakeholders were uncomfortable with the status quo and they wanted to see these changes, they would need to assume transformational leadership to “bring about innovation and change ... and [challenge] the status quo” (Daft, 2010, p. 424). No doubt implementing these changes would require HIM stakeholders adopting a leadership sharing approach (Smith, 2013); and a transformational leadership approach that is focused on inspiring commitment to goals, challenging them to be innovative problem solvers, developing leadership capacity, and supporting them (Bass & Riggio, 2006; Guay, 2011).

*Academic leaders.* Interviewees offered important suggestions regarding what academic leaders could do to address challenges of recruitment, retention and succession planning among HIM practitioners in Jamaica. Chapter 6 discussed a number of suggestions that interviewees offered for academic leaders to aid with succession planning and the development of the HIM profession. Interviewees’ suggestions for training and developing HIM practitioners aligned with what was found in the literature. For example, leadership training and development initiatives (Johns, 2013; Sheridan, Watzlaf & Fox, 2016); and professional development activities (McWay, 2014; Rothwell, 2010), all aimed at staff development.

Interviewees also suggested that together, academic and policy leaders can communicate and collaborate more to bridge various gaps; and interact more to identify and implement strategies for professional development to aid with retention. In particular, to assist with succession planning, both academic and policy leaders can explore a system of continuing education (CE) and professional development and make these CEs outside of the formal training; while policy leaders could make it mandatory that HIM practitioners take these or similar courses in leadership and management. This need for continuing education to propel the HIM profession, was also expressed by Stoltz (2013) in the literature. These recommendations are not far-fetched but as Bush (2003) suggested, may require transformational leaders to drive stakeholder engagement toward the achievement of these goals.

In congruence with the suggestions offered by interviewees, the literature proposed leadership development programmes to create opportunities for aspiring and developing leaders to improve their skill sets while nurturing their leadership talents and capabilities (Bozer, Kuna & Santora, 2015). This means succession planning strategies with planned training and development to: equip HIM practitioners as successors and to build capacities so they could assume both followership and leadership roles (Green, 2011); develop a new pool of leaders with the right mix of talents (Pinnix, 2015); ensure talent sustainability (Bozer, Kuna & Santora, 2015); and allow seamless transition when HIM practitioners are ready to move on or separate from the organisation (Olson, 2008). In addition, as Cooper (2009) advocated, an active succession plan for the next generation of HIM practitioners. Academic and policy leaders may be better positioned to carry out these initiatives if they embrace systems thinking to assess the organisation as a whole in order to understand what is happening within (Krishnamurthy, 2013).



Furthermore, because it is practical at any time, systems thinking can be used in any area of HIM, and it could be applied using different methods (Haines, 2016).

***External stakeholders' involvement in recruitment, retention and succession planning in HIM in Jamaica.*** Interviewees reported minimal involvement of external stakeholders in recruiting, retaining, and succession planning of HIM practitioners in Jamaica. As explained in Chapters 5 and 6, with regards to succession planning, except for (invited) external stakeholders making guest presentations aimed at encouraging staff toward professional development, other local agencies are at times involved only in capacity building as they assist with training. The single international organisation mentioned has also been integral in capacity building for the HIM profession in Jamaica; as it continues to identify and address training needs.

Notwithstanding the foregoing, interviewees expressed concern that external stakeholders were not as involved as they could have been because of a lack of initiation or engagement by the HIM leaders and the professional body. While this may be true, it does not prevent external stakeholders who have identified needs to state their interests and offer scholarships or other support. After all, it may be an avenue for human capital development. As Almendarez (2013) elucidated, the essence of human capital theory is that provision of formal education is considered an important investment in human capital in a population, formal education is essential to expanding the productive capacity of a population, by increasing the intellectual capacities of those who are economically productive. While this sort of stakeholder involvement would address issues of training, it would also help to address issues of remuneration for HIM practitioners in that education would increase their capabilities, these in turn would increase their levels of productivity which would ultimately lead to increased earnings (Strober, 2001).

In the literature, Milner (2008) noted interest-convergence as a principle entrenched in matters of giving up in order to gain. Interest divergence / interest convergence could be incorporated into HIM practices in Jamaica where HIM stakeholders can gradually unite interests to promote interest convergence (Bearce & Bondanella, 2007). Borrowing from Bell (2009), external stakeholders may need to converge interests toward capacity building of HIM practitioners. This could mean that envisioning the positive impact that trained HIM practitioners could have on the country, external stakeholders assess the current HIM environment, then give up their preferences to be in their comfort zones in terms of leaving their physical locations or sharing their skills and resources, and pooling efforts to meet the needs identified. In the end, all parties would gain in that HIM practitioners would be trained and equipped, stakeholders would receive better HIM services, and the corporate image of all stakeholder organisations would be improved. However, for this to be realised, HIM leadership and management must initiate engagement with external stakeholders.

#### **7.6 Theme 5 - Policies and Procedures in HIM.**

This final theme arises from responses regarding availability of HIM procedures and policies for training, orientation, and practice, how these were communicated to the staff, and the relevance and currency of such policies and procedures. Leading and managing HIM require having relevant, current, clear and comprehensive policies and procedures (Fuller, 2007; McWay, 2014) to effectively guide departmental processes and operations.

*Availability of policies and procedures guiding HIM.* Two-thirds of survey participants reported awareness of the policies regarding HIM training and orientation, while a little below that figure reported they were oriented to these policies. However, there were disparities in the results of both data sets. As discussed in Chapter 6, interview responses were in sync with the

14% minority who reported unawareness of policies and procedures for both HIM training and orientation. They clarified that general training policies were in place but none was specific to HIM. This lack of policies can be problematic as according to Fuller (2007), policies and procedures are necessary tools to ensure clarity, standardisation, equity, and consistent work quality.

Responses in relation to the availability of policies and procedures for the actual HIM practice were similar as both survey participants and interviewees shared that policies and procedures were in place to guide the HIM practice. While policy manuals were in place to guide the HIM practice (Ministry of Health, 2002), interviewees reported that there were no established procedures and policies in place for HIM orientation, thus there were no standardised way of doing HIM orientation. Instead, HIM leaders employed different means to orient their staff and did what they thought was effective enough to guide their new recruits. But, as absence of clear policies create chaos and confusion, there should be established procedures and guidelines for both HIM orientation, training and practice to mitigate lack of standardisation and scant orientation; and to allow for transparency in the practice.

In the literature, Miller (2016) described policies as “roadmaps”; and Fuller (2007) underscored the importance of clear and comprehensive policies in organisations to allow for clarity in processes. Since policies guide decision-making and establish “the parameters for taking action and meeting objectives” (McWay, 2014, p. 326), HIM practitioners must appropriately use policies to communicate standard organisational processes and to guide employees’ actions. These policies would also help to increase performance levels for employees and ultimately the organisation (Mishra & Smyth, 2015) because policies “establish

boundaries or limitations on the direction the organization will take in the future” (McWay, 2014, p. 326).

HIM organisations need to invest in appropriately orienting practitioners to the policies and procedures guiding their practice (Mishra & Smyth, 2015). This would ensure that transactions are guided by a clear “series of interrelated steps that are documented and used to provide standardization to routine tasks or problems” (McWay, 2014, p. 326). In addition, policies and procedures would help to specify how the work should be done and how the policies should be applied (Fuller, 2007). Hence, procedures work in tandem with policies and provide detailed guidelines on how to execute roles and meet organisational goals.

Could the absence of procedures and guidelines mean that HIM organisations in Jamaica have embraced the chaos theory? As stated in the literature, “chaos theory teaches that long-term success is not ensured by the plan, but by sticking to the purpose and core values of the organization” (Burns, 2002, p. 50). But the question remains, how can an organisation stick to its purpose without clear policies and procedures? Koehler, Kress, and Miller (2014) expressed that in chaos theory, understanding of minor changes can eventually cause unexpected, major changes in an organisation. Indeed, that is a possibility. But what if it does not? More importantly, what if those unexpected, major changes detract from the organisation’s purpose and mission, or create more chaos? Considering the vital and sensitive nature of their work, HIM organisations can benefit only from that bit of the chaos theory which suggests that leadership is practiced throughout the organisation as each individual can impact its processes (Burns, 2002). Such mind set would lead HIM practitioners to seek after, use, and adhere to established policies and procedures to fulfill the organisation’s purpose and mission.

***Communicating HIM policies and procedures to staff.*** HIM leaders shared that the policies and procedures were communicated to practitioners in a number of ways, mainly during orientation. Sixty-five percent of survey participants reported that they were aware of the policies and procedures for the HIM practice. However, just over 58% reported that they were oriented to these policies and procedures. If these policies were what guide their practice no doubt one would be concerned about the 35% of participants who were unaware of the policies and procedures guiding their practice, and the 42% who could not confirm that they were oriented to these policies and procedures. Once again, the results of the interview shed some light. As shared by Policy Leader 2, to a lesser extent, HIM policies and procedures were communicated during supervisory visits.

Academic leaders reportedly were not satisfied that enough time was taken to properly communicate procedures and policies to the HIM staff. This unease is understood particularly because of the fickle means by which practice leaders reported sharing such important information. They shared that the content of the policies and procedures manual was communicated to the staff in a number of ways but mainly during initial orientation to the job; and in some instances, new recruits were given the manuals to read and at times answer questions posed by the senior HIM staff.

The researcher found nothing in the literature to support communicating vital information via these unsound means. The methods of information sharing described here are not only poor. They are akin to only theoretical classroom learning which Schatz (1997) cautioned that while these are good, there needs to be active engagement through a learning-by-doing approach, such that learning is relevant and practical. Moreover, as Schank, Berman, and Macpherson (2013) advanced people would be more likely to remember when they learn the processes by engaging

with them. Learning these important policies should be practical; not just theoretical, and as Keeton (1983) posited decades ago, through practical experiences, the practitioners would be directly engaging and interacting with the policies and procedures; and those practical experiences result in more effective learning and application. More importantly, considering the sensitive nature of HIM, practice leaders and policy leaders must synergise to clearly and comprehensively communicate these policies and procedures to practitioners (Fuller, 2007).

***Relevance and currency of HIM policies and procedures.*** The results of the survey revealed that over 70% of participants agreed that the HIM policies and procedures in Jamaica were relevant to the practice, while a meagre 37% agreed that these policies and procedures were current and up-to-date. An undecided response of 24% to the question of relevance doubled when they responded to the question of currency of these policies and procedures. Based on these responses, it appears most of the HIM staff were either not familiar with the policies and procedures; or practitioners were just not interacting with them and using them enough to determine their relevance and currency. However, there were contradictions in these results. Interviewees reported that the policies and procedures were somewhat relevant to the practice but needed to be revised to ensure standardisation of the HIM practice across all four health regions, and to align with current and changing HIM practices locally and internationally. This is another area that leadership and management need to give attention because if the “roadmaps” (Miller, 2016) are not current, how can they be used as guides?

If, as stated in Chapter 6, 65% of participants were aware of these policies and procedures, how could 71% of participants, 6% more than those who were aware, then report that these policies and procedures were relevant to the HIM practice? By themselves, these results are difficult to unravel; and again, there were disparities in the responses. Interviewees unanimously

reported that much of the content in the procedures manual was relevant to the practice because the information was still being used. However, the procedures manual was developed over 15 years ago (Ministry of Health, 2002); and with new data needs and the growing adoption of electronic processes, various changes have taken place in the HIM practice since then. In fact, considering the current hybrid (paper-based and electronic) environment in HIM organisations, much of the information in the procedures manual was dated rendering it inadequate to guide the current HIM practice.

As the data revealed, the lacking uniformity of processes may have been attributed to the inadequate policies and procedures that were being used to guide the practice, and the absence of the documented guidelines to allow for standardisation of processes (McWay, 2014). Since the available policies and procedures lacked relevance and currency, they are no longer effective. The onus is therefore on HIM leaders and managers to ensure that HIM organisations have relevant and current policies and procedures in place to specify how the work should be done; and to help ensure quality, consistency, and desirable outcomes for these organisations (Fuller, 2007).

As earlier stated, the HIM department is the core of any health institution and the roles of HIM practitioners are too sensitive to execute without appropriate policies and procedures. To change these policies, procedures and processes, HIM leaders must share ideas and draw on the experience and expertise of others (Fullan, 2004) within the HIM context and with related competencies. In addition, in this dynamic HIM era with all its complexities and interrelatedness, “governance policies and principles must be inspired by systems thinking” (Krishnamurthy, 2013, p. 205). Therefore, HIM organisations should put systems thinking to work for the advancement of the HIM profession.

In summary, there is a hybrid of leadership practices in Jamaica's HIM organisations but it appears leadership is fragmented. However, more collaborative types of leadership are desired to converge leadership ideas and practices. Also, leadership development initiatives are needed to develop new leaders and build competencies. A number of issues with leadership, recruitment, retention, and succession planning are present among HIM practitioners in Jamaica. However, HIM (practice, academic, and policy) leaders must work synergistically to address the issues identified and effectively lead HIM. By engaging other stakeholders in these processes, the benefits can be mutual and immense.

Leading the HIM path in Jamaica can only be effective if the appropriate "roadmaps" are used (Miller, 2016). HIM practitioners were operating without appropriate guides as the policies and procedures that should be used to guide their orientation, training and practice were either absent, dated or lacking. With the numerous changes in the HIM practice and new data needs, HIM leaders and managers need to lead a complete overhaul of the policies and procedures; and develop new policies to appropriately guide their operations, standardise their practices, and align with current and developing trends in HIM, nationally, regionally, and globally.

## **7.7 Summary of Findings.**

The most important findings of this study can be summarised as:

***Leadership is fragmented.*** –The approaches to leadership are fragmented and it is felt that because of the clinical and sensitive nature of HIM, one would expect to find more convergent types of leadership where one supports the other but this was not so. For example, in one department, individuals were doing their own thing and not working with or supporting one another, and in such instances one leadership approach did not compliment the others, and this led to frustration and lack of enthusiasm among the staff. In one instance, one leader was



accommodating inputs through his participative leadership style, the other was autocratic, and the senior took a laissez faire approach; and this left the staff confused.

***Lack of standardisation and lack of transparency.*** There were challenges to recruitment, retention, and succession planning among HIM practitioners; and these are underpinned by leadership issues such as lack of transparency, lack of standardisation of processes, and the absence of a comprehensive manpower plan. Different groups of stakeholders were involved but were playing minimal roles and the professional body was not engaging the key personnel to address these issues and move the profession forward.

***Policy and practice gaps.*** HIM practitioners were operating without the appropriate guides because the policies and procedures were dated and or lacking. The policy and procedures manual was developed in 2002, thus, at the time of the study, it was 16-years-old, and so many changes have taken place in the HIM practice since then. For example, with electronic health records and a number of processes in HIM now electronic, there is need for policies to guide these electronic transactions but the existing policy manual only addresses manual transactions. Therefore there is need for clear policies and procedures to guide these electronic transactions, and address other new developments in HIM.

## Chapter 8 - Implications and Conclusions

### 8.1 Implications of the findings of the study

In relation to the above interpretations, the researcher has identified five implications for leading HIM in Jamaica. These are captioned as: (1) approaches to leadership; (2) people leadership – succession planning (capacity building and professional development); (3) practice leadership - structures, systems, and processes; (4) policy leadership – leading guided by policies and procedures; and (5) synergy in leadership – pooling leadership resources to successfully lead, manage and teach HIM in Jamaica.

**8.1.1 Approaches to HIM leadership.** By way of the undecided responses to the questions of leadership in participants' departments, and leadership practices in HIM, it appears some participants were reluctant to describe the types of leadership in their departments. As outlined in the previous, section, HIM leaders practiced a more transactional type of leadership and there were varying views about how leadership was practiced and how it can or should be improved. There is consequently a need for HIM leaders at all levels (institutional, regional and national) to change their *modus operandi* and execute more winsome approaches to leadership that would also help to build relationships and capacities in the varied HIM institutions. This would help to enhance staff perceptions of leadership, their attitude towards leadership, their knowledge of leadership, and their understanding of how leadership could be practiced for reciprocal benefits. It is imperative that HIM organisations embrace different types of shared leadership, such as the transformational and distributed types that could see others getting involved in leadership development activities, thus allowing them to rise above their own expectations and purposefully engage as they also develop into effective leaders.

**8.1.2 People leadership.** This implication has to do with arrangements to facilitate succession planning. Miller (2016) considers people leadership as purposeful attention to individuals in order to address their needs within an organisation. He posited that “people leadership is a serious *political* business” in organisations “where there are multiple personalities and competing interests” (p. 99). It therefore requires assertiveness and having the right plans and programmes in place to facilitate capacity building and professional development of their staff. This has implications for succession planning and the future of HIM leadership.

Without the appropriate plans, programmes, and activities in place to facilitate capacity building and professional development in Jamaica, HIM organisations may retard their own growth and development. Further, organisational leadership may impede their own capabilities and their potential to grow and develop to meet changing HIM leadership needs. In Chapters 1 and 5, the researcher came across the interesting paradox that senior HIM practitioners do not want to take on leadership roles fearing their incompetence to manage and lead. There needs to be different approaches to people leadership to uncover those potentials through application of the learning-by-doing theory; by having individuals engaging and interacting with leadership (Keeton, 1983; Schatz, 1997) to learn how to become leaders, and to teach those who manage how to also be leaders (Troupe, 2010). Furthermore, as discussed in Chapter 6, HIM organisations need to embrace specific activities such as staff rotation as an ongoing and internal professional development initiative (Miller, 2016).

**8.1.3 Practice leadership.** This involves having the right structures, systems, and processes in place to guide recruitment, orientation, training, retention, succession planning and the various transactions in the HIM practice. Chapter 5, described issues surrounding lack of standardisation in these processes. As participants in this research described the processes of recruitment,

retention and succession planning among HIM practitioners in Jamaica, these processes were tainted with different types of interferences (Miller, 2013a). Chapter 6 also highlighted a challenge to release staff for training so they can be equipped. Again, this was due to absence of the correct structures, systems, and processes to facilitate planned and purposeful training as a critical part of the succession planning process. Purposeful intervention is needed; the delay of which could be to the detriment of HIM education, training, and practice. If HIM leaders continue to operate ‘business as usual’, without the required structures, systems and processes it could gradually destroy the fibre of the HIM profession. Therefore, to mitigate these and other issues and prejudices, HIM leaders must manage and lead using clearly established structures, systems, and processes.

**8.1.4 Policy leadership.** This involves spearheading the development of appropriate policies and leadership and management guided by policies and procedures for standardisation of HIM practices. The lack of standardisation of practices, described in Chapter 6, puts HIM practitioners and all other parties at a disadvantage and exposure to perpetuated errors. By not having current policies and procedures in place to guide the HIM practice, HIM practice leaders were at risk of leading their staff in varied and unclear paths. This reflected negatively on the HIM policy leaders who should have been monitoring trends and developments in HIM, and engaging in upgrading and revising of policies and procedures to ensure consistency and standardisation within the practice. By extension, these dated policies and procedures negatively affected the work of HIM academic leaders and how HIM training was being conducted especially those aspects for which the trainees were being guided to undertake tasks as they were done in the current HIM practice.

As Gibson, Abrams, and Crook (2015) advanced, HIM practitioners are equipped to contribute to policy development and they need to be the leaders in such processes. Because of the key roles that they play, their expertise is beneficial to address policies and procedures in information management processes. Not only do HIM practitioners contribute to policy development, but they must lead within the contexts of departmental, organisational, and national policies. Thus, policy leadership would use the appropriate “fuel” and “roadmaps” (Miller, 2016) for charting clear “direction the organization will take” (McWay, 2014, p. 326); and to “establish the overall context of [HIM institutions], and to provide a framework within and through which [these policy] leaders perform their duties” (Miller 2018, p. 20).

**8.1.5 Synergy in HIM leadership.** To address the issue of fragmented leadership, this synergy in leadership requires pooling leadership resources to successfully lead, manage and teach HIM in Jamaica. An issue raised in Chapter 5 is lack of recognition of the work and worth of HIM because people do not understand what the profession is about and its importance; and the concern that even some HIM practitioners were not placing value on their work. This calls for united efforts to educate people about HIM and the importance of the profession, train and equip HIM practitioners to function effectively, and appropriately lead and manage HIM. This also requires all relevant stakeholders engaging in meaningful research to inform HIM education, leadership, management, and practice. If all stakeholders do not work together to address the prevailing issues, professional growth and development will continuously be hindered. Additionally, unless there is a fuse of practice, policy, and academic leadership and the professional group to lead others to initiate the required processes, the desired changes will not be effected. Absence of this kind of synergy in leadership may be a pyrrhic victory for HIM in Jamaica.

### **8.1.6 Summary of Implications**

The implications of this research can be summarised in terms of implications to (a) the field of HIM, (b) the practice of HIM educators and professionals, and (c) policy makers.

In terms of implications for the field of HIM, this study informs other areas of HIM leadership and management where more investigations are required such as HIM training, standardisation of processes, leadership development programmes, and continuing HIM education, all through the lens of leadership. Since Jamaica relies so heavily on Canada for expertise, it would be interesting to examine these issues (through the lens of leadership) in those contexts to provide a related body of research for data comparison.

In terms of implications for the practice of HIM, there is need for arrangements to facilitate capacity building and professional development of HIM practitioners; so HIM organisations need to embrace specific activities such as staff rotation and leadership development programmes as ongoing professional development initiatives.

In terms of implications for policy makers, HIM leaders also need to spearhead the development of policies and ensure that leadership and management are guided by policies and procedures for standardisation of the HIM practice and smooth running of the departments. Policies are needed to provide guidance and to dictate clear procedures for HIM training and professional development; to reflect global current trends and to anticipate further changes in HIM.

## **8.2 Implications for more research**

More in-depth studies are needed into specific areas of leadership and management of HIM practices in Jamaica, particularly in areas where a number of issues were raised such as training, standardisation of processes, leadership development programmes for HIM practitioners; and other continuing education; all through the lens of leadership and management. There is also the need for more related studies within the Jamaican context.

It would be also interesting to replicate and extend this study in the wider Caribbean context, and since Jamaica depends on Canada for HIM consultation, possibly to examine these issues in the Canadian context to provide a related body of empirical data.

## **8.3 Reflections and Conclusions**

**8.3.1 Reflections.** The researcher embarked on this study with intent to answer some important questions pertaining to leadership in HIM. The focus was on what leadership practices were present in HIM settings, the reasons they were happening, and whether there were arrangements in place to address these existing problems; what (academic and policy) leaders can do to address such challenges; stakeholders' role in succession planning and the development of the HIM profession, and policies that were in place to guide HIM activities—particular focus was on leadership, succession planning, policies and procedures.

Initial expectation of the researcher was that it would be a smooth data collection process and so the researcher was hopeful of a hassle-free process to find answers to the research questions. However, it was overly frustrating trying to get permission to enter the facilities where most participants were located but the HIM practitioners and the directors in the Ministry of Health were willing to facilitate the investigation and so the researcher pressed on. The researcher was

encouraged by the article *Getting past the Gatekeeper* (Miller, Kelly, & Spawls, 2013), which was a motivation to persevere.

Without a doubt, not only were the research questions answered. During the process, a lot more was learnt about HIM policy and practice in Jamaica. The researcher also learnt about unexpected issues that are likely to arise during a research and strategies to deal with them. Although a five year journey, this research was the beginning of a number of phases for the researcher as this study opened several windows to peek into the inconspicuous practices of HIM through the lens of leadership. Furthermore, the process helped with personal development as a researcher and as a HIM academic. Prior to this research, the researcher had not used a mixed methods approach or a purposeful qualitative design. It was therefore the researcher's first mixed-methods study and first data gathering endeavour using interviews – the pilot study being the ground-breaking opportunity. This new ground taught the researcher valuable lessons such as how to appropriately conduct research interviews, what to expect during research interviews, and how to manoeuvre both time and resources to ensure successful interviews.

The researcher was quite timid about conducting the interviews, particularly with those in senior positions such as the directors as it was felt they would probably be too busy to facilitate the interviews. However, this exercise taught the researcher patience and has helped to heighten the researcher's confidence level such that similar challenges engaging in subsequent processes can be averted. It had been a rich experience and at the same time a very humbling one as the researcher interacted with HIM practitioners and stakeholders at all levels. There are varied new paths to tread, new hypotheses to test, and new prospects to unravel and to understand.

The researcher has to agree with Creswell (2014) that it is a challenge to analyse data using this convergent parallel mixed-methods design, and that challenge is how to actually merge the



data to derive meaning. However, the researcher was guided to analyse each data set separately, then collate both. Looking beyond the limitations of this study, which were few in terms of unavailability of related literature and personal limitations, the researcher is grateful for the learning opportunities and the many experiences realised through this exercise and is truly humbled by these experiences.

**8.3.2 Conclusions.** This study provides valuable contribution to the HIM practice in Jamaica by flagging issues and informing about more appropriate and prudent recruitment, retention, and succession planning practices that may be adopted; the importance of adherence to established policies and procedures to guide the practice; and leadership types and practices that may be adopted in Jamaican organisations servicing, training, leading and managing HIM. Conclusions are grouped into three parts: (a) HIM practice in Jamaica, (b) HIM Policy in Jamaica, and (c) HIM Leadership in Jamaica. These are described below.

*HIM Practice in Jamaica.* Health information management in Jamaica is practiced through carefully executed processes by trained practitioners and on-the-job orientation to transactions but, as stated in Chapter 5, the profession lacks trained practitioners. Orientation lacks standardisation and on-the-job training is at times hampered by the absence of up-to-date policies and procedures. There was an obvious disconnect regarding matters of succession planning. While HIM practitioners and practice leaders were indecisive in their responses to whether an established succession plan was in place for HIM, academic leaders and policy leaders were more forthright with their responses and some spoke definitively about the absence of such documents and processes, and the need for them.

Leadership is fragmented. The issues raised were all linked to people leadership and practice leadership, already discussed in the Implications section. In organisations “where there are

multiple personalities and competing interests” (Miller, 2016, p. 99), effective people leadership is required to give attention to individuals in order to address their needs; and to have the right plans and programmes in place to facilitate capacity building and professional development of the staff. This has implications for succession planning and the future of HIM leadership. As regards practice leadership there is need to bolster practice leadership by having the right structures, systems, and processes in place to guide recruitment, orientation, training, retention, succession planning and the various other transactions in the HIM practice. The relevant stakeholders also need to initiate measures for filling HIM leadership gaps through mentoring (Abrams, Giannangelo & Schneider, 2014); and creating opportunities for HIM practitioners to learn leadership by practicing leadership (Schank, Berman, & Macpherson, 2013).

The profession could benefit from particular aspects of the chaos theory by practicing leadership throughout the organisation so each individual can contribute to the process (Burns, 2002) and sharing ideas to address the issues of fragmentation in leadership and management (Galbraith, 2004) in the practice.

*HIM Policy in Jamaica.* HIM practice in Jamaica suffers from the absence of relevant and current policies and procedures. This study highlights the need for national and institutional HIM policies. National policies for standardisation of HIM processes regarding recruitment, retention and succession planning; equity of opportunities for upward mobility, and transparency in the granting of benefits (such as training and study leave) to HIM practitioners. More specifically, this study appeals for institutional level policies regarding how HIM departments should recruit, retain, and develop HIM practitioners; how to equip HIM practitioners to assume positions of leadership and management; and strategies/initiatives that may be implemented toward institutional effectiveness. Hence the need for, as described in the previous section,

policy leadership to spearhead the overhaul and development of appropriate policies.

Furthermore, policy leadership is needed to ensure leadership and management are guided by appropriate policies and procedures; as well as for transparency and standardisation in the HIM practice.

*HIM Leadership in Jamaica.* Leadership in HIM in Jamaica is executed using a hybrid of approaches. Although this blend of leadership practices and styles allows for creativity and flexibility, leadership is fragmented. Leadership and management are at times dappled as both processes are tarnished by unclear processes, prejudiced transactions, religious, social, and other connections (Miller, 2013a). Of necessity is for HIM leaders to change their approach to leadership and embrace different types of shared leadership that will have them involving others in leadership development activities and purposefully engaging as they also develop into [more] effective leaders. HIM policy, academic, and practice leaders need to share the burden of leadership (Smith, 2013); and adopt more communal types (Fullan, 2004) to identify energies in their staff and engage them (Guay, 2011). This will help HIM practitioners to hone their skills, merge talents, and build leadership competencies to provide effective leadership within their organisations (Harris, 2008; Hill-Berry, 2015). Leadership and management must always be cognisant that as Miller (2018) argues, context shapes leadership and leadership shapes context; so flexibility and adaptability are also required in the HIM context but not without procedural compliance.

In relation to all three aspects, this study has created opportunities for HIM practice, policy, and academic leaders to reflect on their processes and make (or recommend) the necessary adjustments. For academic leaders, this study proposes a review and adjustment of both HIM curricula, and expansion of HIM training through leadership and management short courses,

facilitating in-service workshops and seminars, and continuing education seminars on leadership and management. For policy leaders, this study informs an overhaul of the current policies and procedures, and development of new and appropriate policies to support, orientation, training, and practice; and to meet the changing HIM needs and to provide an appropriate guide for the practice. For practice leaders, this study suggests opportunities to engage academic and policy leaders for support to better manage and lead within the confines of those policies, to identify means for continuing professional development and capacity building of practitioners, and to engage in purposeful activities geared toward building other leaders. As discussed in the Implications, this requires synergy in leadership for all three groups (policy, practice, and academic leaders) to unite efforts to ensure that all stakeholders are appropriately informed of such policies and that there is compliance with these policies for standardisation and clarity in the HIM practice.

*Summary of Conclusions.* This study provides a foundation to engage in professional dialogue among all stakeholders to create opportunities for building competencies and sharing expertise in training, leading, and managing HIM. Based on the researcher's summary of the main conclusions, a number of issues were identified that if addressed could help to advance theory and or practice in HIM. The issues raised are all linked to people and practice leadership. In these HIM organisations where there are multiple personalities and competing interests (Miller, 2016), effective people leadership is required to give attention to individuals in order to address their needs; and to have the right plans in place to facilitate capacity building and professional development of the staff; and as Schank, Berman, & Macpherson (2013) advised, to create opportunities for people to learn leadership by practicing leadership.

On the basis of all the conclusions made, this study makes valuable contribution to the existing body of knowledge. While doing the literature search, the researcher was challenged to find literature that examined some HIM practices, particularly in relation to leadership. This study therefore contributes to the existing literature by evaluating the HIM practices through the lens of leadership. The convergent parallel mixed methods approach used in this study also added insights into an appropriate pairing of methods that may be replicated to provide “richness” (Creswell, 2008) to future HIM studies. Once again, the study contributes to research in that it provides empirical evidence of how HIM is managed and led in the actual practice, and in the academic institution. Additionally, this study provides a springboard for closer evaluation of recruitment, retention, succession planning of HIM in Jamaica, and the policies that inform these processes, thorough the lens of leadership. It also provides for an empirically informed understanding of how HIM is taught, lead and managed in Jamaica; and for application of such understanding in the wider HIM context.

The researcher encourages all HIM colleagues and leaders in the health information management profession to *lead well in your practice as you also lead others to lead.*

## References

- Abrams, K., Giannangelo, K., & Schneider, S. (2014). New Name of the HIM Game. *Journal of AHIMA*, 85(2). 34-39.
- Al-Husseini, S., Elbeltagi, I., & Dosa, T. (2013). The effect of transformational leadership on product and process innovation in higher education: An empirical study in Iraq. Paper presented at the 1-X. Retrieved October 3, 2013 from <http://search.proquest.com/docview/1368589694?accountid=35539>
- Almendarez, L. (2013). Human Capital Theory. *Caribbean Quarterly*, 59(3/4), 21-33.
- Al-Sawai, A. (2013). Leadership of healthcare professionals: where do we stand? *Oman Medical Journal*, 28(4), 285-7.
- Al-Zefeiti, S.M.B. & Mohammad, N.A. (2015). Methodological Considerations in Studying Transformational Leadership and its Outcomes. *International Journal of Engineering Business Management*, 7 (Godište 2015), 7-10. <https://doi.org/10.5772/60429>
- American Health Information Management Association. (2014). Foundation of Research and Education. Retrieved from <http://www.schoolsoup.com/scholarship-directory/state/AHIMArS>
- American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author
- Arnold, K. A. & Loughlin, C. (2013) "Integrating transformational and participative versus directive leadership theories: Examining intellectual stimulation in male and female leaders across three contexts", *Leadership & Organization Development Journal*, 34(1), pp.67 – 84
- Ary, D., Jacobs, L. C., Sorenson, C. K., & Walker, D. A. (2014). *Introduction to research in education* (9th ed.). United States: Cengage

- Basham, L. M. (2012). Transformational leadership characteristics necessary for today's leaders in higher education. *Journal of International Education Research*, 8(4), 343. Retrieved October 3, 2013 from <http://search.proquest.com/docview/1433384104?accountid=35539>
- Bass, B. M. & Riggio, R. E., (2006). *Transformational Leadership*, (2nd ed.). New York: Taylor and Francis
- Bearce, D. H. & Bondanella, S. (2007) 'Intergovernmental Organizations, Socialization, and Member-State Interest Convergence', *International Organization*, 61(4), pp. 703–733. doi: 10.1017/S0020818307070245.
- Becker, G. S. (1994). Human Capital revisited. In G.S. Becker (Ed.), *Human Capital: A Theoretical and Empirical Analysis with Special Reference to Education* (3rd ed). Chicago: The University of Chicago Press (p. 15 - 28)
- Becker, G. S. (1993). *Human Capital: A theoretical and Empirical Analysis, with Special Reference to Education*, (3rd ed.). Chicago: University of Chicago Press
- Bell, D. (2009). On Celebrating an Election as Racial Progress. *Human Rights*, 36(4), 2-5.
- Best, J. W. & Kahn, J. V. (2006). *Research in education* (10th ed.). Boston MA: Allyn and Bacon
- Bogdan, R. G., & Biklen, S. K. (2003). *Qualitative research for education: An introduction to theories and methods* (4th. ed.). Boston MA: Allyn and Bacon
- Bolden, R. (2011). Distributed Leadership in Organizations: A Review of Theory and Research. *International Journal of Management Reviews*. 13, 251–269  
doi: 10.1111/j.1468-2370.2011.00306.x
- Bolding, D. J. (2013, January 1). Factors Influencing Role Behaviors by Professional Exemplars in Hospitals. *ProQuest LLC*,

- Bostanci, A. B. (2013). The Prediction Level of Teachers' Organizational Citizenship Behaviours on the Successful Practice of Shared Leadership. *Eurasian Journal of Educational Research*, (51), 177-194. Retrieved from EBSCOhost
- Bourdieu, P. (1986). The Forms of Capital. In J. E. Richardsun (Ed.), *Handbook of Theory of Research for the Sociology of Education*. Greenwood Press
- Bozer, G., Kuna, S., & Santora, J. C. (2015). The Role of Leadership Development in Enhancing Succession Planning in the Israeli Nonprofit Sector. *Human Service Organizations: Management, Leadership & Governance*, 39(5), 492-508.  
doi:10.1080/23303131.2015.1077180
- Breton, T. R. (2014). *A human capital theory of economic growth: New evidence for an old idea*. St. Louis: Federal Reserve Bank of St Louis. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/1698194886?accountid=11526>
- British Educational Research Association. (2011). Ethical Guidelines for Educational Research. Retrieved from <https://www.bera.ac.uk/wp-content/uploads/2014/02/BERA-Ethical-Guidelines-2011.pdf>
- Burns, J. S. (2002). Chaos theory and leadership studies: Exploring uncharted seas. *Journal of Leadership & Organizational Studies*, 9(2), 42-56. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/203145050?accountid=11526>
- Bush, T. (2003). *Theories of Educational Leadership and Management*. (3rd ed.). London: SAGE Publications Ltd.



- Canadian Health Information Management Association. (2008). About us. Retrieved from <https://www.echima.ca>
- Canadian Health Information Management Association. (2008). Retrieved from <https://www.echima.ca/history>
- Cole, G. A., & Kelly, P. (2011). *Management theory and practice* (7th ed.). United States: South Western Cengage
- Coleman, J. (1988). Social Capital in the Creation of Human Capital. *American Journal of Sociology*, 94, S95-S120. Retrieved from <http://www.jstor.org/stable/2780243>
- Colmer, K. (2017). Collaborative Professional Learning: Contributing to the Growth of Leadership, Professional Identity and Professionalism. *European Early Childhood Education Research Journal*, 25(3), 436-449.
- Cooper, H. (2009). Changing roles of Health Information Managers: An education perspective. *Health Information Management Journal*, 38(3), 38-42.
- Corson, D. (2000). Emancipatory leadership, *International Journal of Leadership in Education: Theory and Practice*, 3(2), 93-120. DOI: 10.1080/136031200292768
- Creswell, J. W. (2016). *30 Essential skills for the qualitative research* London: SAGE.
- Creswell, J. W. (2015). *A concise introduction to mixed methods research*. London: SAGE.
- Creswell, J. W. (2014). *Research Design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). London: SAGE.
- Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Boston: Pearson Merrill/Prentice Hall.

- Crosby, R. A., DiClemente, R. J. & Salazar, L. F. Eds. (2006). *Research Methods in Health Promotion*. San Francisco, CA: Jossey-Bass
- Daft, R. L., (2010). *Management* (9th ed.). United States: South-Western College Publishers
- Daft, R. L., & Marcic, D. (2012). *Management: The new workplace* (8th ed.). United States: South Western Cengage
- DeVry University. (2013). Educational Leadership Concentration. Retrieved from <http://www.devry.edu/degree-programs>
- Diamond, J. B., & Spillane, J. P. (2016). School Leadership and Management from a Distributed Perspective: A 2016 Retrospective and Prospective. *Management in Education*, 30(4), 147-154.
- Donnor, J. K. (2005). Towards an interest-convergence in the education of African-American football student athletes in major college sports. *Race Ethnicity and Education*, 8(1), 45–67.
- Duffus, K. (2017). Recruitment of records management practitioners in Jamaica’s public sector and its implications for professional practice. *Records Management Journal*, 27(2), 205-222. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/1919995689?accountid=11526>
- Edgerton, J. D. & Roberts, L.W. (2014). Cultural Capital or habitus? Bourdieu and beyond in the explanation of enduring educational inequality. *Theory and Research in Education* 12(2) 193-220
- Egbo, E. (2005). Emergent Paradigm: Critical Realism and Transformative Research in Educational Administration. *McGill Journal of Education*. 40(2). 267-284

- Ellinger, L. K., Trapskin, P. J., Black, R., Kotis, D., & Alexander, E. (2014). Leadership and Effective Succession Planning in Health-System Pharmacy Departments. *Hospital Pharmacy*, 49(4), 369–375. <http://doi.org/10.1310/hpj4904-369>
- Europa World Plus. (2018). Jamaica, in Europa World online. London, Routledge. University of Technology Jamaica. Retrieved 13 November 2018 from <http://www.europaworld.com/entry>
- Fowler, F. J. (2009). *Survey research methods* (4th ed.). London: Sage
- Fullan, M. (2004). Systems thinkers in action: moving beyond the standards plateau. Department for Education and Skills. DfES/1060/2004
- Fuller, S. R. (2007). Principles of Work Planning and Organization. In M. L. Johns (Ed.). *Health Information Management Technology: An Applied Approach*. 2nd ed. Chicago, Illinois: AHIMA
- Fuller, S. (2002). Introduction to Organisation and Supervision. In M. L. Johns (Ed.). *Health information management technology: An applied approach*. Chicago, Illinois: AHIMA
- Galbraith, P. (2004). Organisational leadership and chaos theory: Let's be careful. *Journal of Educational Administration*, 42(1), 9-28.
- Gall, M. D., Gall, J. P., & Borg, W. R. (2007). *Educational research: An introduction* (8th ed.). Boston: Pearson Publishers.
- Gay, L. R., Mills, G. E. & Airasian, P. (2012). *Educational research: Competencies for analysis and applications* (10th ed.). Boston: Pearson Publishers.
- Gibson, C. J., Abrams, K. & Crook, G. (2015). "Health Information Management Workforce Transformation: New Roles, New Skills and Experiences in Canada" *Perspectives in Health Information Management* (International issue, May 2015).

- Green, D. A. (2011). Successful succession planning. *Long-Term Living: For the Continuing Care Professional*, 60(2), 42-44.
- Greenfield, D., Braithwaite, J., Pawsey, M., Johnson, B., & Robinson, M. (2009). Distributed leadership to mobilise capacity for accreditation research. *Journal of Health Organization and Management*, 23(2), 255-67. doi: <http://dx.doi.org/10.1108/14777260910960975>
- Guay, R. P. (2011). *Igniting the fire between leaders and followers: The impact of having the right fit* (Order No. 3461387). Available from ABI/INFORM Collection; ProQuest Dissertations & Theses Global. (880288364). Retrieved from <https://search.proquest.com/docview/880288364?accountid=35539>
- Haines, S. (2016). *The systems thinking approach to strategic planning and management*. CRC Press.
- Harris, A. (2008). Distributed leadership: according to the evidence. *Journal of Educational Administration*. 46(2), 172-188. doi 10.1108/09578230810863253
- Harris, A. & Spillane, J. (2008). Distributed leadership through the looking glass. *Management in Education*. 22 (1) 31-34. doi: 10.1177/0892020607085623
- Hayden, W., Jr. (1991). *Professionalism with respect to the leadership behaviour of social work administrators* (Order No. NN69334). Available from ProQuest Dissertations & Theses Global. (303963314). Retrieved from <https://search.proquest.com/docview/303963314?accountid=35539>
- Heritage, D. (2011). Succession Planning, Models of Leadership and School Improvement. (n.p.) Retrieved from <https://www.sheffield.gov.uk/education/schoolgovernors/guidance/policiesandprocedures/leadershipdevelopmentsuccessionplanning.html>

- Hill-Berry, N. P. (2016). Professionalism among Jamaican Educators: Principles, Practices, and the Practitioners' Perspectives. In C. Bissessar (Ed.), *Assessing the Current State of Education in the Caribbean*. Pennsylvania: IGI Global
- Hill-Berry, N. P. (2015). Infusing Distributed Leadership for Capacity Building and Organisational Effectiveness: Is this the Journey for a Select Jamaican College? *The Bridge: Journal of Educational Research-Informed Practice* 2(2): Special Edition 6-27.
- Hopkins, D. & Higham, R. (2007). System leadership: mapping the landscape. *School Leadership and Management*. 27(2). pp. 147 – 166. DOI: 10.1080/13632430701237289
- Hotho, S. (2008). Professional identity - product of structure, product of choice. *Journal of Organizational Change Management*, 21(6), 721-742. doi: <http://dx.doi.org/10.1108/09534810810915745>
- Huffman, E. K. (1994). *Health information management* (10th ed.). Berwyn, Illinois: Physicians' Records Company
- Hunt, T. J. (2014). Leader-Member Exchange Relationships in Health Information Management. *Perspectives in Health Information Management*, 11(Spring), 1d.
- Johns, M. L. (2013). Breaking the Glass Ceiling: Structural, Cultural, and Organizational Barriers Preventing Women from Achieving Senior and Executive Positions. *Perspectives in Health Information Management / AHIMA, American Health Information Management Association*, 10(Winter), 1e.
- Johns, M. J. (2007). (Ed.). *Health information management technology: An applied approach*. (2nd. ed.). Chicago, Illinois: AHIMA
- Johns, M. J. (2002). (Ed.). *Health information management technology: An applied approach*. Chicago, Illinois: AHIMA

- Keeton, M. (1983). Is Experience the Best Teacher? *Innovation Abstracts*, 5(11).
- Khalifa, M., Dunbar, C. & Douglasb, T. (2013). Derrick Bell, CRT, and educational leadership 1995 – present, *Race, Ethnicity and Education*, 489-513.
- Kidney, E., & Manning, J. (2017). Reflecting on reflexivity: Stories of leveraging identity in the field. Paper presented at the 187-193. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/1967313895?accountid=11526>
- Kipnis, E., & Broeckerhoff, A. (2016). Strategies for reconciling positionality dynamics in a 'homecomer-stranger' international research team. Paper presented at the 136-142. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/1803829825?accountid=11526>
- Koehler, G. A., Kress, G. G., & Miller, R. L. (2014). What disaster response management can learn from chaos theory. *Crisis and Emergency Management: Theory and Practice*, 178, 111.
- Krishnamurthy, R. (2013). Architecture Leadership and Systems Thinking. *A Systemic Perspective to Managing Complexity with Enterprise Architecture*, 192.
- Kumar, R. DC. (2013). Leadership in healthcare. *Anaesthesia & Intensive Care Medicine*, 14(1), 39-41.
- Laverty, M. J. (2016). Thinking My Way Back to You: John Dewey on the Communication and Formation of Concepts. *Educational Philosophy and Theory*, 48(10), 1029-1045.
- Lee, C. (2007). Cultural convergence: Interest convergence theory meets the cultural defense. *Ariz. L. Rev.*, 49, 911.
- Leedy, P. D., & Ormrod, J. E. (2010). *Practical research: Planning and design* (9th ed.). New Jersey: Merrill/Prentice Hall.

- Leggat, S. G. (2009). A guide to performance management for the Health Information Manager. *Health Information Management Journal* 38(3): 11-17.
- Lewis, C. A. (2012). *Extracts from trip reports CAST Course Background* Unpublished report.
- Lunenburg, F. G., & Ornstein, A. C. (2012). *Educational administration: Concepts and practices* (6th ed.). United States: Wadsworth Cengage
- Marta, F. B., Sanzo Perez, M. J., & Trespacios Gutierrez, J. A. (1999). Training in small business retailing: Testing human capital theory. *Journal of European Industrial Training*, 23(7), 335-352. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/215396070?accountid=11526>
- Martin, B., Cashel, C., Wagstaff, M., & Breunig, M. (2006). *Outdoor leadership: Theory and practice*. Retrieved from <http://books.google.com.jm/books?id=D4ewmFjesOcC&pg=PA126&dq>
- Maryland State Department of Education. (2006). Leadership Succession Planning Guide for Maryland Schools. Retrieved from <http://www.marylandpublicschools.org>
- McCallum, D. (2013). Teachers as Leaders: Building the middle leadership base in Jamaican schools. In P. Miller (Ed.) *School leadership in the Caribbean: Perceptions, practices, paradigms*. United Kingdom: Symposium Books
- McLean, E., Scale, M., & Rouse-Jones, M. D. (2016). Preparing Tomorrow's Library Managers: Exploring Leadership and Succession Planning at the University of the West Indies Libraries. In I. Management Association (Ed.), *Leadership and Personnel Management: Concepts, Methodologies, Tools, and Applications* (pp. 2239-2266). Hershey, PA: IGI Global. doi:10.4018/978-1-4666-9624-2.ch102

- McWay, D. (2014). *Today's Health information management: An Integrated approach* (2nd ed.). New York: Cengage
- Melvin, B. K. (2011, January 1). Teacher Perceptions of Administrative Leadership Practices and the Impact on Retention. *ProQuest LLC*,
- Mertler, C. A. & Charles, C. M. (2011). *Introduction to educational research*. (7th ed.). United States: Pearson
- Middleton, J. J. (2012). *Transformational leadership through the lens of chaos* (Order No. AAI3454516). Available from PsycINFO. (941024331; 2012-99031-052). Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/941024331?accountid=11526>
- Miller, P. (2018). *The Nature of School Leadership: Global Practice Perspectives*. Palgrave Macmillan
- Miller, P. (2016). *Exploring school leadership in England and the Caribbean: New insights from a comparative approach*. London: Bloomsbury
- Miller, P. (2014). What is a Principal's Quality Mark? Issues and Challenges in Leadership Progression among Primary Teachers in Jamaica. *Research in Comparative and International Education* 9(1), 126 – 136
- Miller, P. (2013a). Corruption as Redemption? Affiliation as a mark for leadership progression among primary school teachers in Jamaica. *Journal of Education and Practice*, 4(24), 170-180.
- Miller, P. (2013b). (Ed). *School leadership in the Caribbean: Perceptions, practices, paradigms*. London: Symposium Books.



- Miller, P., Kelly, K. & Spawls, N. (2013). Getting Past the Gatekeeper: Safeguarding and Access Issues in Researching HIV+ Children in Jamaica. *Policy Futures in Education* 11(2) 167-174
- Mills, S., & Stewart, J. (2015). The doctoral research of doctoral researchers; experiences of being an insider researcher. Paper presented at the 437-XII. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/1721001639?accountid=11526>
- Milner, H. R. (2008). Critical Race Theory and Interest Convergence as Analytic Tools in Teacher Education Policies and Practices. *Journal of Teacher Education* 59(4), pp. 332 - 346 doi: 10.1177/0022487108321884
- Miner, J. B. (2005). *Organizational Behaviour: Essential theories of motivation and leadership*. New York: M.E. Sharpe Inc.
- Ministry of Health. (2018). Health Portfolio. Retrieved from <https://www.moh.gov.jm/about-us/health-portfolio/>
- Ministry of Health. (2016). *Policy and Procedure Manual for the Referral and Transfer of Patients*.
- Ministry of Health. (2002). Procedures Manual - Health Records Services
- Mishra, V. & Smyth, R. (2015). Workplace policies and training in China: evidence from matched employee-employer data. *International Journal of Manpower*, 36(7), pp. 986-1011.
- Morrison, D. (2018). Whose Interests and under Whose Control?: Interest Convergence in Science-Focused School-Community Collaborations. *Cultural Studies of Science Education*, 13(1), 85-91.

- Newman, D., & Newman, N. (2010). Training in support of leadership development at the University of the West Indies, Mona Campus Library. *Journal of Workplace Learning*, 22(6), 394-401. doi:<http://dx.doi.org.libaccess.hud.ac.uk/10.1108/13665621011063496>
- Nixon, B. (2003). Leading business transformation – learning by doing. *Industrial and Commercial Training*, 35(4), 163-167. doi-  
[org.libaccess.hud.ac.uk/10.1108/00197850310479150](http://org.libaccess.hud.ac.uk/10.1108/00197850310479150)
- Nugent, P. (2008). Moving On Up. *American School Board Journal*, 195(8), 32-35.
- Odom-Wesley, B., Brown, D., & Meyers, C. L. (2009). *Documentation for medical records*. Chicago, Illinois: AHIMA
- Odumeru, J. A., & Ogbonna, I. G. (2013). Transformational vs. transactional leadership theories: Evidence in literature. *International Review of Management and Business Research*, 2(2), 355.
- Olson, L. (2008). Cultivating a Taste for Leadership. *Education Week*, 27(33), 20.
- Ontario Ministry of Education. (2009). Leadership Succession Planning and Talent Development. Retrieved from  
[http://www.edu.gov.on.ca/eng/policyfunding/memos/november09/ols\\_talentdevelopment.pdf](http://www.edu.gov.on.ca/eng/policyfunding/memos/november09/ols_talentdevelopment.pdf)
- Othman, R., & Sumardi, W. A. (2013). Talent management at Tenaga Nasional Berhad. *Asian Case Research Journal*, 17(2), 289. Retrieved from  
<http://search.proquest.com/docview/1506166879?accountid=35539>
- Pieterse, A. N., Van Knippenberg, D., Schippers, M., & Stam, D. (2010). Transformational and transactional leadership and innovative behavior: The moderating role of psychological empowerment. *Journal of Organizational Behavior*, 31(4), 609-623.

- Pinnix, D. (2015). Lead your engineering firm into the future. *Consulting-Specifying Engineer*, 52(11), 48.
- Piper, A. T. (2012). *A happiness test of human capital theory*. St. Louis: Federal Reserve Bank of St Louis. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/1699259035?accountid=11526>
- Punch, K. (2009). *Introduction to Research Methods in Education*. London: SAGE
- Rashid, A. (2016). Managerial ownership and agency cost: Evidence from Bangladesh. *Journal of Business Ethics*, 137(3), 609-621.  
doi:<http://dx.doi.org.libaccess.hud.ac.uk/10.1007/s10551-015-2570-z>
- Rather, A. R. (Ed.) (2004). *Theory and principles of education*. Retrieved from <http://books.google.com.jm/books?id=yyLbZAlCSukC&pg=PA143&dq>
- Roberts, J. (2007). Health Information Technology Functions. In M. Johns (Ed.). *Health information management technology: An applied approach* (2nd ed.) Chicago, Illinois: AHIMA
- Rothwell, W. J. (2010). *Effective succession planning: Ensuring leadership continuity and building leaders from within* (4th. ed). Retrieved from <http://books.google.com.jm/books?id>
- Rubenstein, D. (2014). Intergenerational Leadership. A discussion with attendees of the Texas State University. Health Information Management Spring Conference. Retrieved from <http://www.txstate.edu/continuinged/Events/HIM-Spring-Conference.html>
- Schaeffer, D. M., & Rouse, D. (2014). Effective Academic Advisory Committee Relationships. *Contemporary Issues in Education*, 7(1).

- Schank, R. C., Berman, T. R. & Macpherson, K. A. (2013). Learning by Doing. In C. M. Reigeluth (Ed.), *Instructional-Design Theories and Models: A New Paradigm of Instructional Theory, Volume 2*. New York: Routledge
- Schatz, M. (1997). Why We Don't Teach Leadership in Our MBA Programmes. *Journal of Management Development*, 16(9), 677-79.
- Schein, E. H., & Schein, E. (1978). *Career dynamics: Matching individual and organizational needs* (Vol. 24). Reading, MA: Addison-Wesley.
- Senge, P. (1990). *The Fifth Discipline*. New York: Doubleday
- Senge, P., Hamilton, H., & Kania, J. (2015). The Dawn of System Leadership. *Stanford Social Innovation Review*, 13(1), 26-33.
- Sharma, R. & Gopalkumar, N. (2017). The shifting landscape of health information management: An education and career perspective. *HIM-Interchange* 7(1)
- Sheridan, P. T., Watzlaf, V., & Fox, L. A. (2016). Health Information Management Leaders and the Practice of Leadership through the Lens of Bowen Theory. *Perspectives in Health Information Management*, 13(Spring), 1d.
- Slay, H.S. & Smith, D. A. (2011). Professional identity construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities. *Human Relations* 64(1) 85–107. doi: 10.1177/0018726710384290
- Smith, L. (2013). Together We Can: Sharing the Burden of Leadership. In P. Miller (Ed.), *School leadership in the Caribbean: Perceptions, practices, paradigms*. United Kingdom: Symposium Books

- Spence Laschinger, H. K., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management* 17, 302–311
- Spillane, J. P. (2009). Managing to Lead: Reframing School Leadership and Management. *Phi Delta Kappan*, 91(3), 70-73.
- Spillane, J., Halverson, R., & Diamond, J. (2004). Towards a Theory of Leadership Practice: A Distributed Perspective. *Journal of Curriculum Studies*, 36(1), 3-34.
- Stanfield, J. (2009). The rise and fall of Human Capital Theory. *Economic Affairs*, 29(1), 100.  
doi:<http://dx.doi.org.libaccess.hud.ac.uk/10.1111/j.1468-0270.2009.01881.x>
- Stoltz, P. G. (2013). Embracing change Ensures Career Resilience: AQ Online Program Helps HIM Professionals Manage Adversity. *Journal of AHIMA*, 84(8). 20-22.
- Strober, M. H. (2001). Human Capital Theory: Implications for HR Managers.
- Strober, M. H. (1990). Human capital theory: Implications for HR managers. *Industrial Relations*, 29(2), 214. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/222383648?accountid=11526>
- Strachan, M. (2009). Managing change proactively within the current HIM professional domain. *Health Information Management Journal* 38(3) 7-10
- Sullivan, G. M., & Artino, A. R. (2013). Analyzing and interpreting data from Likert-type scales. *Journal of graduate medical education*, 5(4), 541-2.
- Talan, T. (2010). Distributed leadership: Something new or something borrowed? *Leadership*.
- Taylor-Powell, E., & Renner, M. (2003). *Analyzing qualitative data*. University of Wisconsin.  
Retrieved from [http://books.google.nl/books/about/Analyzing\\_Qualitative\\_Data](http://books.google.nl/books/about/Analyzing_Qualitative_Data).

- Thomas-Gregory, A. (2014). Professional Identities of Middle Managers: A Case Study in the Faculty of Health and Social Care. *Educational Management Administration & Leadership*, 42(5), 620-639.
- Tindigarukayo, J. K. (2004). An assessment of public service reforms in Jamaica. *Social and Economic Studies*, 53(3), 81-109,177. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/222744096?accountid=11526>
- Troupe, D., 2010. *Developing results-based leadership attributes and team cohesiveness through action learning*, Walden University.
- Trowers, L. L. (2016, March 1). Improving Student Engagement of Health Services Management Students. *Online Submission*
- University of Minnesota. (2014). Leadership in Health Information Technology for Health Professionals Certificate. Retrieved from <http://www.nursing.umn.edu/leadership>
- University of Technology, Jamaica. (2016). Health Information Technology. Retrieved from [http://www.utech.edu.jm/colleges\\_faculties/chsc/sahw/progs/uadheitfx.html](http://www.utech.edu.jm/colleges_faculties/chsc/sahw/progs/uadheitfx.html)
- University of Technology, Jamaica (2013). *Associate of Science Degree in Health Information Technology Self Study*. Unpublished report.
- van, d. M. (2010). Does human capital theory account for individual higher education choice? *The International Business & Economics Research Journal*, 9(6), 81-93. Retrieved from <https://search-proquest-com.libaccess.hud.ac.uk/docview/518743516?accountid=11526>
- Villar, A. (2008). Response Bias. In P. J Lavrakas (Eds), *Encyclopedia of survey research methods*. doi: <http://dx.doi.org/10.4135/9781412963947>
- Webb, L. (2006). Learning by doing. *Development and Learning in Organizations: An International Journal*, 20(5). doi: 10.1108/dlo.2006.08120ead.001

- Wellington, J. & Szczerbinski, M. (2007). *Research methods for the social sciences*.  
London: Continuum International Publishing Group
- Wiersma, W. & Jurs, S. T. (2009). *Research Methods in Education: An introduction* (7th ed.).  
United States MA: Allyn and Bacon
- Wood, J. N., Finch, K., & Mirecki, R. M. (2013). If We Get You, How Can We Keep You?  
Problems with Recruiting and Retaining Rural Administrators. *Rural Educator*, 34(2) --,
- World Health Organization. (2013). Health systems in urban disasters. Retrieved from  
[http://www.who.int.ezproxy.utech.edu.jm/kobe\\_centre/publications/Health-systems-in-urban-disasters\\_2013/en/](http://www.who.int.ezproxy.utech.edu.jm/kobe_centre/publications/Health-systems-in-urban-disasters_2013/en/)
- World Health Organization. (2010). Increasing access to health workers in remote and rural areas  
through improved retention: Global policy recommendations
- Zeng, X., Reynolds, R., & Sharp, M. (2009). Redefining the Roles of Health Information  
Management Professionals in Health Information Technology. *Perspectives in Health  
Information Management / AHIMA, American Health Information Management  
Association*, 6(Summer), 1f.

## Appendices

### *Appendix A*

#### **Health Facilities by Health Region**

<b>Geographical Area</b>	<b>Health Centres</b>	<b>Hospitals</b>
<b>North East</b>	Port Antonio St. Ann's Bay	Port Antonio St. Ann's Bay Annotto Bay Port Maria
<b>South East</b>	Morant Bay Windward Road Slip Pen Road Maxfield Park St. Jago Park	Princess Margaret Victoria Jubilee Kingston Public Bustamante Hospital for Children Spanish Town Linstead
<b>Southern</b>	Black River	Black River Mandeville May Pen Percy Junor Lionel Town
<b>Western</b>	Falmouth Creek Street / Mo-Bay Lucea	Falmouth Cornwall Regional Noel Holmes Savanna- La- Mar



**HIM Practitioner's Questionnaire****University of Huddersfield**

School of Education and Professional Development

**Instructions**

This questionnaire has three sections: A, B & C. Please fill in the information below and answer the following questions by placing a tick (✓) in the appropriate box and writing your recommendations on the lines provided. Only one response is required for each item in sections A and B.

**This survey requires about 15 - 20 minutes of your time.**

**Section A – Demographic Data**

- |  |  |  |
|--|--|--|
| 1. What is your health region?   | <input type="checkbox"/> NERHA<br><input type="checkbox"/> SRHA  | <input type="checkbox"/> SERHA<br><input type="checkbox"/> WRHA  |
| 2. What is your sex?   | <input type="checkbox"/> Male  | <input type="checkbox"/> Female  |
| 3. What is your age range?   | <input type="checkbox"/> Below 25 years<br><input type="checkbox"/> 36 - 45 years  | <input type="checkbox"/> 25-35 years<br><input type="checkbox"/> 46 years and over   |
| 4. Which of the following <b>best</b> describes the number of health information management (HIM) staff at your institution? | <input type="checkbox"/> 1 - 5<br><input type="checkbox"/> 11 - 15<br><input type="checkbox"/> 21 - 25<br><input type="checkbox"/> Over 30                             | <input type="checkbox"/> 6 - 10<br><input type="checkbox"/> 16 - 20<br><input type="checkbox"/> 26 - 30                          |
| 5. How long have you worked in HIM?  | <input type="checkbox"/> Less than one year<br><input type="checkbox"/> 1 - 5 years<br><input type="checkbox"/> 11- 15 years<br><input type="checkbox"/> Over 20 years | <input type="checkbox"/> 6 - 10 years<br><input type="checkbox"/> 16 - 20 years  |
| 6. What type of institution do you work in?  | <input type="checkbox"/> Type 4 H/C<br><input type="checkbox"/> Type 5 H/C<br><input type="checkbox"/> Specialist hospital   | <input type="checkbox"/> Type A hospital<br><input type="checkbox"/> Type B hospital<br><input type="checkbox"/> Type C hospital |

**Section B – Leadership, Recruitment, Retention & Succession Planning Policies, and Practices in your institution**

**Questions 7 - 41 are based on your experience in your department. Using the key below, please select the most appropriate answer.**

**Key: SD Strongly disagree D Disagree U Undecided A Agree SA Strongly agree**

<b>Leadership in my department:</b>	<b>SD</b>	<b>D</b>	<b>U</b>	<b>A</b>	<b>SA</b>
7. Demonstrates commitment to personal and professional development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Creates opportunities for personal and professional development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Inspires and motivates staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Continues to seek new ways of getting things done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Allows us to participate in decision-making processes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Provides opportunities for staff to participate in leadership activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Seeks to build leadership competencies in staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Encourages staff members who never want to take a leading role to get involved.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Are more task-oriented than people-oriented (focus on the work more than the people)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Leadership Practices affecting HIM</b>	<b>SD</b>	<b>D</b>	<b>U</b>	<b>A</b>	<b>SA</b>
16. HIM staff displays confidence in their superiors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. HIM staff is willing to take on leadership roles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. HIM supervisors display confidence in leading others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. There is evident leadership capacity in the existing HIM staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. HIM practices are in line with established procedures and guidelines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. It is easy to identify people to fill HIM leadership positions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### **Recruitment & Retention**

22. My department adheres to established methods for recruiting HIM staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. My department is usually timely with recruitment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I find my job fulfilling and feel valued being a HIM practitioner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Employee retention helps the development of my department.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Measures/programs are in place to retain HIM practitioners.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. In my department, communication is excellent – Supervisors take time to listen to employees, we are usually informed of what is going on and what to expect (the direction of the organisation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Succession planning</b>	<b>SD</b>	<b>D</b>	<b>U</b>	<b>A</b>	<b>SA</b>
28. Adequate support is in place to facilitate HIM practitioners accessing formal training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. My department has a leadership succession planning in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. My department identifies potential talents in HIM and develops staff to fill senior positions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. The next head of my department is likely to be identified from within my department.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. In my dept, succession planning is practiced by grooming and promoting leaders from within.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Appropriate measures are in place to ensure that when senior HIM staff leaves, the position can be easily filled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. As part of succession planning, department heads are involved in mentoring and coaching the staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Policies affecting HIM</b>					
35. I am aware of policies regarding academic requirements for entry into the HIM profession.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. I am aware of the policies affecting HIM training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. I have been oriented to the policies affecting HIM training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. I am aware of the policies and procedures affecting HIM practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. I have been oriented to the policies and procedures affecting HIM practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. The HIM policies are relevant to the practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. The HIM policies are current and up-to-date.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Section C

**Please answer these two questions in relation to your department.**

42. What roles do health information managers play in succession planning (capacity building and professional development)? (Please list)

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43. What roles do health information managers play in the development of the HIM profession? (Please state)

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**Thank you for participating.**

## ***Appendix C***

### **Interview Schedule for HIM Academic and Policy Leaders**

#### **University of Huddersfield**

School of Education and Professional Development

**Date:** \_\_\_\_\_

**Time started:** \_\_\_\_\_

**Time ended:** \_\_\_\_\_

**Venue:** \_\_\_\_\_

**Interviewee's Pseudonym:** \_\_\_\_\_

#### **Introduction:**

- Interviewer will exchange greeting with interviewee and explain the purpose of the exercise and state how long the interview is expected to last.
- Before interview begins, interviewer will explain confidentiality of information, rights of interviewee, and protection of interviewee.
- Interviewer will request permission to record the interview. If the interviewee denies such permission, interviewer will handwrite note during the interview.

#### **Interview Guide**

1. What leadership practices currently exist among HIM practitioners?  
Probe:
2. How are HIMs recruited in Jamaica?  
Probe:
3. Who takes part in the recruitment process and what roles do they play?  
Probe:
4. What measures are in place to retain HIM practitioners in Jamaica?  
Probe:
5. What is it like trying to identify people to fill HIM leadership positions?  
Probe:

6. How would you respond to the statement that “the HIM training institution in Jamaica, can easily identify people from the field to assume leadership roles”?  
Probe:
7. Is there an established HIM succession plan in place? If yes, what does it entail?  
Probe:
8. What are some of the challenges in relation to recruitment, retention and succession planning among HIMs in Jamaica? What arrangements exist to address these problems?  
Probe:
9. What can (academic and policy) leaders do to address the challenges identified regarding recruitment, retention and succession planning among HIM practitioners in Jamaica?  
Probe:
10. Are external stakeholders involved in the processes of recruiting, retaining, and succession planning of HIM practitioners in Jamaica? If yes, what role do they play?  
Probe:
11. What role do HIM managers have in succession planning (capacity building and professional development) and the development of the HIM profession?  
Probe:
12. How has the impact (of # 11) been measured and assessed by different stakeholders?  
Probe:
13. (a) Are there established procedures and policies in place regarding HIM training, orientation, and practice?  
(b) How are these communicated to the staff?  
(c) How relevant and current are these policies to the HIM practice?  
Probe:

**End of interview:**

Interviewer will thank interviewee and explain that if necessary, follow-up contact will be made with the interviewee.

**Researcher:** Nola Hill-Berry

**Supervisor:** Professor Paul Miller

## ***Appendix D***

### **HIM Practitioner's Consent Form**

#### **University of Huddersfield**

School of Education and Professional Development

Dear participant:

#### **Re: Study titled Leading HIM in Jamaica**

You are being asked to participate in a research which investigates health information management policies and practices in Jamaica. This survey is geared towards individuals who are practicing HIM as their job. We are seeking your participation in providing general feedback on Health Information Management at your institution.

Your participation will help us to evaluate existing leadership practices, identify strategies to build leadership capacities, as well as review policies and practices guiding HIM. Your participation should be mutually benefitting in that it is an opportunity to assess your own work context. Also, upon completion, the outcomes along with recommendations for improvements will be presented to the Ministry of Health.

**Protection from harm.** You will not be exposed to any physical or psychological harm; will not have to face any form of embarrassment, be bombarded by any unusual distress, nor suffer any damage to your self-esteem.

**Confidentiality and anonymity.** Your right to privacy will be respected to ensure anonymity and confidentiality. The identity of those who participate will not be divulged as your correct names will not be used. Instead, code numbers will be assigned to each questionnaire as a means of tracking the information. All data collected will be properly secured so that only the researcher will have access to them.

**Voluntary participation.** No one will be pressured, forced or persuaded to be a part of the study. Any refusal to participate in the study will be respected. Your participation is voluntary and should you decide, you have a right to withdraw at any time without prejudice.

**Consent.** If you agree take part, please sign this consent form indicating that you are properly informed and are therefore expressing consent to participate by completing the questionnaire.

---

Researcher  
Date:

---

Participant  
Date:

Thank you for agreeing to take part in this survey



## ***Appendix E***

### **Codebook for HIM Questionnaire**

#### **University of Huddersfield**

School of Education and Professional Development

#### **Section A**

- |                              |                        |                            |
|------------------------------|------------------------|----------------------------|
| 1. Health Region:            | 1 = NERHA              | 2 = SERHA                  |
|                              | 3 = SRHA               | 4 = WRHA                   |
|                              |                        |                            |
| 1. Sex:                      | 1 = male               | 2 = female                 |
|                              |                        |                            |
| 2. Age range:                | 1 = below 25 years     | 2 = 25 - 35 years          |
|                              | 3 = 36 - 45 years      | 4 = 46 years and over      |
|                              |                        |                            |
| 3. HIM staff at institution: | 1 = Less than 5        | 2 = 6 - 10    3 = 11 - 15  |
|                              | 4 = 16 - 20            | 5 = 21 - 25    6 = 26 - 30 |
|                              | 7 = Over 30            |                            |
|                              |                        |                            |
| 4. Years worked in HIM?      | 1 = Less than one year | 2 = 1 - 5 years            |
|                              | 3 = 6 - 10 years       | 4 = 11 - 15 years          |
|                              | 5 = 16 - 20 years      | 6 = Over 20 years          |

5. Institution:
- |                          |                     |
|--------------------------|---------------------|
| 1 = Type 4 Health Centre | 4 = Type C hospital |
| 2 = Type 5 Health Centre | 5 = Type B hospital |
| 3 = Specialist hospital  | 6 = Type A hospital |

### **Section B – Leadership, Policies, Practices and Succession Planning in HIM institutions**

For questions 7 – 41:

- |                  |                       |                    |
|------------------|-----------------------|--------------------|
| 0 = Missing data | 1 = Strongly disagree | 2 = Disagree       |
| 3 = Undecided    | 4 = Agree             | 5 = Strongly agree |

### **Section C**

For questions 42 & 43

Open-ended data analysis will be done

## ***Appendix F***

### **Letter and Consent Form for Interviewees**

#### **University of Huddersfield**

School of Education and Professional Development

You have been selected to participate in a research that I am undertaking with the University of Huddersfield. Participation will require you being interviewed regarding leadership practices in health information. This interview will take 40 – 50 minutes.

If you agree to be interviewed, I would like to take notes and record our conversation for use in the preparation of my report. Your name and personal information will not be used or revealed in the text and you will remain anonymous. The type of organisation and data on your work may be required so that the data can be properly contextualised.

**Protection from harm.** You will not be exposed to any physical or psychological harm; will not have to face any form of embarrassment, be bombarded by any unusual distress, nor suffer any damage to your self-esteem.

**Confidentiality and anonymity.** Your right to privacy will be respected to ensure anonymity and confidentiality. The identity of those who participate will not be divulged as your correct names will not be used. Instead, you will be assigned a “false name” as a means of ensuring anonymity, and no identifying information will be recorded. All data collected will be properly secured so that only the researcher and research supervisor will have access to them.

**Voluntary participation.** No one will be pressured, forced or persuaded to be a part of the study. Any refusal to participate in the study will be respected. Your participation is completely voluntary although there can be mutually benefiting outcomes, in that it will provide an opportunity to re-assess your personal views and experiences while identifying areas for improvement or where changes are needed. Also, upon completion, the outcomes along with recommendations for improvements will be presented to the Ministry of Health. Your participation is voluntary and should you decide, you have a right to withdraw at any time without prejudice.

I foresee no risk of physical injury or ethical issue that may arise from participating in this research. Should you have further questions regarding this research, please contact me at: Nola.Hill-Berry@hud.ac.uk

Or my supervisor

Professor Paul Miller at P.Miller@hud.ac.uk

**Consent.** If you agree take part, please sign the consent form indicating that you are properly informed and are therefore expressing consent to participate by answering interview questions.

### ***CONSENT FORM***

**Title of Research: Leading Health Information Management in Jamaica**

I have been satisfactorily informed about the nature and purpose of this research and I agree to take part in it. I understand that my identity will not be revealed in the report; that the information I share will be kept confidential; and that no other person than the researcher and supervisor will have access to the information I provide. I further understand that I have the right to withdraw from the research at any time without giving any reason.

I am satisfied that I have been duly informed about this research and I am affixing my signature below indicating my willingness to take part by participating in an interview.

Sign: \_\_\_\_\_  
*Researcher*

\_\_\_\_\_  
*Interviewee*

*Date:*

*Date:*

## ***Appendix G***

### **Letter seeking permission from local authorities**

#### **University of Huddersfield**

School of Education and Professional Development

May 22, 2017

Professor Owen Morgan  
Chairman  
Advisory Panel on Ethics and Medico-Legal Affairs  
45 – 47 Barbados Ave  
Kingston 5

Dear Professor Morgan:

#### **Leading Health Information Management in Jamaica: An Evaluation of Policy and Practice**

The captioned research is being conducted under my supervision. The aim of which is to evaluate current leadership practices among health information management (HIM) professionals in Jamaica; and evaluate the policies and practices regarding recruitment, retention and succession planning of HIMs.

The methods that will be used to capture the data to answer the research questions are:  
Survey – Participants will be identified through stratified convenience sampling (each health region as a stratum), to complete a survey questionnaire.

Semi-structured interviews - A total of 17 participants will be interviewed. This will comprise two representatives from each health region, four directors from the Ministry of Health, and five academic leaders (drawn from the head of school, programme leader, and members of the HIM academic advisory committee).

The proposed health facilities are listed in an appendage to the proposal. These include all the public general hospitals, two specialist hospitals and the Type 4 and Type 5 health centres.

I solicit your permission in allowing the researcher to visit your premises (the health facilities listed) to collect data from HIMs who are willing to participate.

For further information, please contact me:

---

**Paul W. Miller, PhD, LLM, MBA**

Principal Fellow - Higher Education Academy  
Professor of Educational Leadership & Management  
University of Huddersfield  
Phone: 01484 478158  
Email: P.Miller@hud.ac.uk

Or the researcher:

**Nola Hill-Berry**

School of Education & Professional Development  
University of Huddersfield  
Phone: 1 876 861 5832  
Email: Nola.Hill-Berry@hud.ac.uk

## Appendix H

### Timeline for Completion of Study

#### University of Huddersfield

School of Education and Professional Development

		2017												2018						
Research Timeline		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Admission & Enrolment (Huds)																				
Submit research plan																				
Edit research proposal																				
Get ethical clearance																				
Seek permission to enter field																				
Pilot both instruments																				
Continue literature review																				
Procure needed items																				
Pilot instruments																				
Progression Feedback																				
Collect data																				
Collate & present findings																				
Discussion and write-up																				
Research ends																				
Present first draft																				
Edit feedback from draft																				
Present final report																				